Doctor-Patient Communication in Consultations for Upper Respiratory Tract Infections: A Discourse Analysis.

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Doctor-patient communication in consultations for upper respiratory tract infections: a discourse analysis

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Thesis presented for PhD degree

I declare that the work presented in this thesis is my own

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(Date) ..... 30th April 2007 .....

Abstract

Illnesses such as upper respiratory tract infections (URTIs, coughs and colds) are positioned within medical discourse as 'minor' and 'trivial', and consulting doctors with cough and cold symptoms is morally accountable.

In this thesis I explore different methodological approaches to understanding doctor-patient consultations for URTIs. I critically review quantitative and qualitative approaches to URTI consultation research, and explore qualitative discursive approaches through analyses of consultation data.

I recruited 16 general practitioners, and 33 patients with cough and cold symptoms. Data comprise 33 video-taped consultations and post-consultation interviews (13 interviews with general practitioners and 13 with patients), supplemented with ethnographic data. I draw from a range of discursive methodological approaches including conversation analysis, socio-linguistic analysis of institutional talk and discursive psychology to analyse these data.

I show how discursive approaches can illuminate the complexity and meaning of doctor-patient interaction, exploring the way that coughing is used by patients as an interactional resource. In a detailed micro-analysis, I show that coughing is associated with interactional problems such as misunderstanding and disagreement, and how it also functions as a resource to assert patients' legitimacy.

In another detailed analysis, I show that the 'minor' status of coughs and colds (and consequent 'no problem' diagnosis) is associated with interactional difficulty for both doctors and patients: I show how doctors' and patients' legitimacy and 'face' are at stake in a contest to define the meaning of cough and cold symptoms (as significant and treatable, or alternatively, 'no problem'). I discuss conflicts between doctors' and patients' interests: for example, prescribing antibiotics may legitimise the patient but discredit the doctor.

I discuss the way that discourse analytic approaches can contribute richer understandings of doctor-patient interaction through detailed analysis of social transactions in consultation (such as the negotiation of identity and face). I contend that discursive approaches represent valuable and under-utilised resources for research and practice in primary care.

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Figures, graphs and appendices

Overview of chapters

This thesis represents a methodological journey through different analytic lenses. I explore different ways of understanding interactions between doctors and patients, focusing on upper respiratory tract infection (URTI) consultations in primary care. I explain how this research came about, in other words, why I chose to study consultations between doctors and patients with URTIs ('coughs and colds') and how I came to view these through discourse analytic lenses. I discuss the challenges to traditional research methods that discourse approaches present, and then show how conversation analysis and discourse analysis can offer interesting insights into doctor-patient interaction in URTI consultations.

In chapter 1, I explain how I came to research URTI consultations. I then explore the academic literature relating to upper respiratory tract infections (URTIs) in two ways. Firstly I draw on literature which reflects a quantitative, population-level focus on patterns of illness, consulting and treatment. I then turn to quantitative and qualitative studies which explore doctor and patient perspectives on URTI illness and consulting. I discuss how different research approaches (quantitative and qualitative) contribute to understanding the social nature of URTI illness and consultation

Chapter 2 continues my account of how this research came about, representing a methodological journey through different research paradigms. I start with a quantitative, positivist paradigm, then discuss constructionist qualitative approaches, and then explore the discursive perspectives which underpin this thesis. I discuss concepts of social construction, face and identity, and explore how these ideas are relevant for understanding URTI consultations.

In chapter 3, I describe the study design, discussing the implications of a discursive approach for sampling, data collection and analysis. I discuss the way that methodological realisations led to changing research aims and different approaches to data analysis.

In chapter 4, I place the study in an ethnographic and discursive context. I explore themes within medical texts and participant interviews to illustrate the wider discursive context in which URTI consultations occur in the UK. I also set the study in an ethnographic context, describing the local setting, participants and events in consultation.

In chapter 5, I draw upon conversation analysis to explore whether coughing could have an interactional significance in communication between doctors and patients, exploring the significance of coughing in turn-by-turn interaction and also in construction of patient identity.

In chapter 6, I draw on a range of discourse analytic tools to bring together concepts of social construction, face and identity, exploring how the nature of URTI illness is linked with maintenance of face and the construction of doctor and patient identity.

In the final chapter, I conclude the thesis by discussing the methodological journey and where it has led, in other words the implications of this work for researchers, practitioners, patients, medical educators and for me personally.

Chapter 1 - Upper respiratory tract illness in primary care: a review of the literature

In this chapter I explain how I came to research upper respiratory tract infection (URTI) consultations. I then explore the academic literature relating to URTIs in two ways: firstly I draw on literature which reflects a quantitative, population-level focus on patterns of illness, consulting and treatment. I shall then turn to quantitative and qualitative studies which explore doctor and patient perspectives on URTI illness and consulting. I discuss how different research approaches (quantitative and qualitative) contribute to understanding URTI illness and consultation.

The next section explains how I came to choose the topic of upper respiratory tract infections.

Why research URTIs?

In the year 2002, I received Department of Health research fellowship funding. I chose URTI consultations as a research topic for two main reasons; the first deriving from clinical experience as a general practitioner (GP) and the second relating to primary care research priorities and opportunities for funding.

Clinical experience

My clinical experience whilst working as a GP reflects some of the contradictions in medical discourse about URTI which I will discuss in this chapter (and chapter 4). I felt puzzled about why people consult with apparently minor, self-limiting URTI symptoms in general practice (e.g. cough, sore throat, running nose). The medical management of upper respiratory illness is intuitively straightforward but there is a medico-legal imperative to exclude serious physical illness. 'Good' doctoring also involves seeking patients' psycho-social hidden agendas, so although URTI symptoms are apparently easy to manage, there is the danger of having misjudged the seriousness or the psycho-social significance of symptoms.

I felt that there were dilemmas about how to steer consultations. For example, patient-centred approaches (Stewart et al. 2003) potentially conflict with the more doctor-centred (or institution-centred) concerns about limiting work-load, promoting self-care and reducing antibiotic prescription rates. I felt uncomfortable in giving advice which on the one hand 'everyone knows' and on the other hand lacks scientific underpinnings. 'Educating' patients about the difference between viruses and bacteria (as a justification for avoiding antibiotic prescription) did not really seem to address patients' concerns. URTIs and patients with URTI symptoms sit on the threshold between medically legitimate and illegitimate illness, and it is uncomfortable being the gatekeeper for access to medical services, with the power to confer or deny medical legitimacy. I wanted to research URTI consultations to think about what might underlie communicative difficulties for doctor and patient, and explore ways that communication could be more 'successful'. My aims changed as the project evolved, as I discuss in chapter 3.

Research policy and funding

This project is funded through a Department of Health Primary Care Researcher Development award. At the time I applied in 2002, there had been several reviews of primary care research that made recommendations for future research directions. Researching URTI consultations with qualitative methodologies fitted with research policy priorities in several ways. Firstly the MRC Topic Review on Primary Health Care identified the management of acute conditions such as respiratory disorders as a research priority since URTI consultations constitute a large proportion of work in primary care (MRC 1997). Secondly, there was emerging consensus that primary care research would benefit from social scientific research approaches, and three reviews recommended drawing from disciplines such as sociology, psychology and anthropology to explore consulting behaviour (Clarke 1999; Mant 1997; MRC 1997). Thirdly, my ambitions for becoming a primary care researcher fitted with the Mant Report's recommendations for developing research capacity in primary care through the training of R&D leaders (Mant 1997). I received full time funding from the National Health Service Research and Development Programme which aims to 'discover more effective evidence-based treatments and establish research as an integral element of primary care' as well as to provide research training for primary care clinicians and non-clinicians (DOH 2004). I have had a very large measure of freedom in deciding the evolution and conduct of this research, with the proviso that it be of some relevance to clinical practice in National Health Service primary care. The PhD has allowed me to

explore territories between academic disciplines, particularly critical thought in anthropology, psychology, sociology and linguistics, and to think about how discursive approaches can deepen understandings of doctor-patient interaction in primary care.

My methodological understanding has evolved over the course of the PhD, and the structure of the thesis reflects this in part: in this chapter I review quantitative and qualitative literature relevant to URTI consultation, and then critique these methodological approaches and explore discursive approaches in the chapters which follow.

Literature review - method

In this thesis I focus on interactions between general practitioners (GPs) and adults with upper respiratory illness since the legitimacy of consulting with URTI is more contested for adults than for children (Kai 1996b; Wright & Morgan 1990) (see chapter 4).

I searched Medline database (1966 to 2003) to gain an understanding of the main priorities and foci within research on URTIs in primary care. Respiratory infections are classified in many different ways on Medline: relevant entries appear in the medical subject heading (MeSH) tree under type of disease (Respiratory tract diseases; Respiratory tract infections), but also under individual symptoms (for example Respiration disorders; cough), anatomical site (for example Pharyngeal diseases; pharyngitis), and infective agent (for example Picornaviridae; common cold). Since these classifications do not necessarily overlap, I combined different search terms to produce an inclusive definition of upper respiratory tract infection (Ashworth et al. 2004) (lines 14 to 23 of the search strategy below). I also included lower respiratory tract infection (LRTI) since upper and lower respiratory tract infections are not easily distinguished clinically, and diagnosis of URTI may depend on exclusion of LRTI. These search terms retrieved 183,226 papers related to URTI or LRTI (line 26).

Medline search strategy

O V I D **MEDLINE**

<1966 to August Week 2 2003>

#	Search History	Results	Display
1	exp Social Sciences/	989871	Display

2	Health Behavior/	9984	Display
3	Attitude to Health/	38594	Display
4	exp KNOWLEDGE, ATTITUDES, PRACTICE/	21658	Display
5	Culture/	13873	Display
6	exp Health Education/	80460	Display
7	explanatory models.mp.	284	Display
8	communication/ or communication barriers/ or language/ or narration/ or nonverbal communication/ or verbal behavior/	56521	Display
9	interpersonal relations/ or professional-family relations/ or professional-patient relations/ or physician-patient relations/	85938	Display
10	exp COMMUNICATION/ or communication.mp. or exp NONVERBAL COMMUNICATION/ or exp COMMUNICATION BARRIERS/	225829	Display
11	8 or 9 or 10	293266	Display
12	anthropology.mp. or exp ANTHROPOLOGY, CULTURAL/ or exp ANTHROPOLOGY/	150195	Display
13	exp SOCIOLOGY, MEDICAL/ or exp SOCIOLOGY/ or sociology.mp.	647462	Display
14	exp Respiratory Tract Infections/	163973	Display
15	(URTI or upper respiratory tract infection$).mp.	1903	Display
16	common cold.mp. or exp Common Cold/	2410	Display
17	rhinorrhoea.mp.	375	Display
18	pharyngitis.mp. or exp PHARYNGITIS/	5378	Display
19	sore throat.mp.	1459	Display
20	exp NASOPHARYNGITIS/	181	Display
21	bronchitis.mp. or exp BRONCHITIS/	23920	Display
22	tonsillitis.mp. or exp TONSILLITIS/	5482	Display
23	exp COUGH/ or cough.mp.	16187	Display
24	(lower respiratory tract infection$ or LRTI).mp.	2101	Display
25	qualitative research.mp. or exp Qualitative Research/	2184	Display
26	14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24	183226	Display
27	primary health care.mp. or exp Primary Health Care/	38681	Display
28	primary care.mp.	25988	Display

29	family practice.mp. or exp Family Practice/	43325	Display
30	27 or 28 or 29	89591	Display
31	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 12 or 13 or 25	1276158	Display
32	26 and 31	11133	Display
33	30 and 32	409	Display
34	26 and 30	1705	Display

I identified work relevant to primary care by combining the MeSH headings Primary Health Care OR Family Practice with textword searches for 'primary health care', 'primary care' and 'family practice' (lines 27-29). This resulted in 89,591 papers, 1705 of which were about URTI or LRTI (line 34). I gained an idea of the focus of interest of these 1705 references by listing the starred MeSH headings (the most important categorisations) for the first 30 of the retrieved references. Using these MeSH heading terms, 554 of the 1705 papers concerned antibiotics or anti-infective agents, 450 focused on diagnosis, 440 concerned therapeutics, 193 were reviews, 165 concerned education (of patient or doctor), 105 were on incidence, prevalence or epidemiology, 80 were classified as health services research or program evaluation, and 55 focused on drug resistance. These categories are not mutually exclusive and they represent the main foci of interest for the papers located on Medline.

The literature review in this chapter is intended to give an overview of different methodological approaches to understanding URTI illness and consultation, focusing especially upon how 'social factors' are conceptualised. To identify papers of most relevance to the project, I used a combination of MeSH headings and textwords to identify articles with social scientific approaches. I used broad concepts to capture articles concerning particular topics (e.g. patient and practitioner beliefs, doctor-patient communication), as well as searching by discipline (e.g. social science, anthropology, sociology) and method (qualitative research) (lines 1-13 and 25 of the search strategy). This resulted in 1,276,158 references (line 31). Combining the groups generated for primary care, URTI and social science resulted in 409 references (line 33). I reviewed the abstracts of these papers, selecting 64 studies as particularly relevant by virtue of their focus on doctor-patient communication in URTI and/or their methodology. I excluded papers if they addressed chronic rather than acute infective respiratory disease (for example tuberculosis, asthma or allergic rhinitis) and papers with a focus on influenza or ear problems. Whilst the symptoms of these conditions overlap with

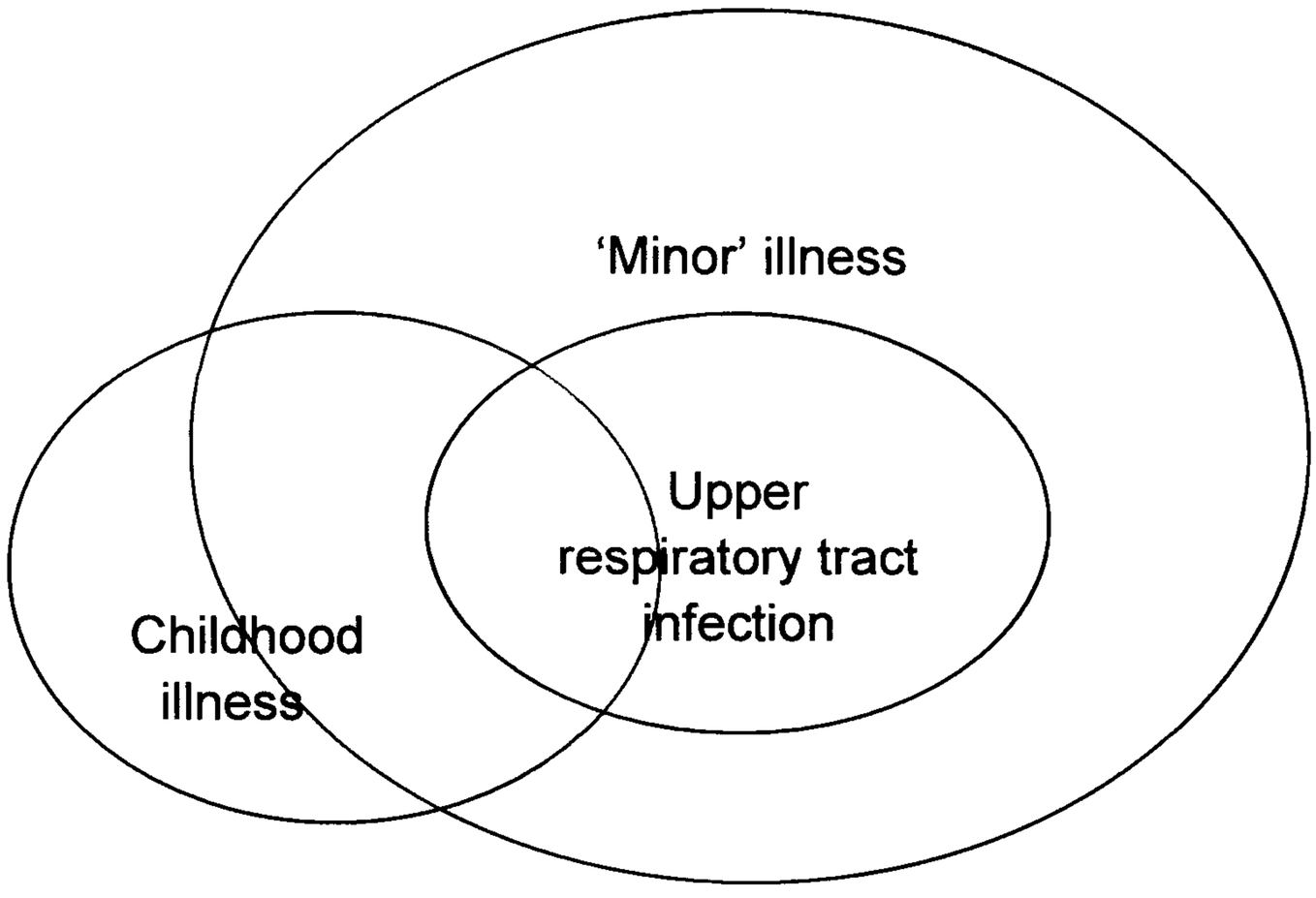
those of URTI, illness aetiology, duration, severity and/or treatments differ from those of URTI.

To access papers within social science databases, I searched the ISI Web of Knowledge Science Citation Index and Social Sciences Citation Index using keywords in strings, for example '(health beliefs OR explanatory models) AND respiratory'. I also used the citation linkage facility to identify articles which had cited particular key works, for example, Helman's ethnographic work entitled 'Feed a Cold, Starve a Fever' (Helman 1978). Finally, I sought papers of methodological interest by hand searching journals such as Qualitative Health Research, Qualitative Inquiry, Communication and Medicine, Sociology and Discourse and Society, and attending conferences such as the annual meetings of the Medical Sociology subgroup of the British Sociological Association and the British Association of Applied Linguistics conference. I also searched citation lists in textbooks such as 'Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction' (Silverman 2001) and 'Discourse, Theory and Practice' (Wetherell et al. 2001). I also searched for publications of particular authors whom I knew had researched URTI in primary care, including Britten N, Butler CC, Kumar S, Thomson KB, Little P, Bradley CP, Kai J, Howie JG, Macfarlane J, and Helman C.

I downloaded the citations and abstracts of all papers and books which seemed relevant onto a Reference Manager 9 database, amassing a total of 1226 citations and obtaining the full text of nearly half of these (555 papers, books or book chapters). I made notes on paper and within Reference Manager, using the RefMan search facility to retrieve citations. The literature review is intended to be illustrative and thorough, but not an exhaustive review of all available papers on URTI in primary care.

Literature about upper respiratory tract infection intersects with literature about childhood illness and literature about minor illness (see diagram 1) and I have drawn on these where they mention URTI illness or URTI consultation behaviour. The primary care literature about URTI tends to focus on children rather than adults: patterns of illness and responses to illness are different for children and adults, but I have drawn upon studies of URTI in children where these seem relevant for understanding illness behaviour. I have drawn upon literature published in English, and mainly relating to health care in Europe and the United States, focusing on allopathic systems of health care rather than alternative, complementary or traditional healing (Helman 2000; McNee et al. 1995). I focus on doctors rather than nurses as health care providers since models of nurse consultation have different traditions and evolution (Anderson et al. 2002; Bradshaw 1999).

Diagram 1: Overlapping academic literatures



This review is located within wider bodies of anthropological, sociological, primary care and epidemiological literature which are relevant for understanding illness, illness behaviour and doctor-patient consultation. A complete review of these literatures is outside the remit of this thesis: I have instead focused on the contribution of these disciplines to the understanding of URTI consultations specifically. I shall first describe a quantitative, population-level view of URTI illness and consultation.

Population-level view of URTI consultations

Incidence of upper respiratory tract infection

Population surveys show that the majority of people suffer with all kinds of symptoms on a daily basis (Morrell et al. 1971; Wadsworth et al. 1971). Upper respiratory symptoms appear to be very common (Morrell & Wale 1976): symptom diaries kept by adults in the mid 90's showed that 50% reported one or more illness episodes over a four week period. More than a third of these were categorised as cold and flu symptoms (Rogers & Nicolaas 1998). Respiratory infections are more common in the winter months in the UK (Fleming et al. 2003).

Consulting health professionals

Most illness is treated without recourse to health professionals (Demers et al. 1980; Hannay 1980; Morrell & Wale 1976; Rogers & Nicolaas 1998). For example, 52% of

Canadian adults reported using over-the counter medications for their last cold, 17% did nothing, 8% reported bed rest and 7% visited a doctor (Vingilis et al. 1999). Similarly, mothers of Scottish children reported managing everyday symptoms with no action (35%) and home nursing including rest, drinks, food, sponging, steam and over-the-counter remedies (65%) (Cunningham-Burley & Irvine 1987).

Despite the fact that only a minority of illness comes to the attention of health care services, the Office of Population Census and Surveys General Practice Morbidity Survey conducted in 1991/2 in the UK showed that nearly 20% of the population consulted for a minor respiratory condition over the course of a year (OPCS 1992)[1]. The consultation rate in primary care for URTIs has been declining since the mid 90s (Ashworth et al. 2004; Fleming et al. 2003; ISD 2004). However, respiratory illness still accounts for a large proportion of GP workload: upper respiratory tract infection and sore throat were both in the top ten reasons for GP consultation in the year 2000 (ISD 2004, Scottish data). The prevalence of URTI in the community means that even if only a small percentage consult health care professionals, this has substantial implications for work-load in primary care (Rovers et al. 2006).

Viral upper respiratory tract infection remains incurable (Fendrick 2003) and there are substantial economic costs in terms of days missed from work, costs to health services (Carabin et al. 1999; Komaroff 1990) and costs of over-the-counter remedies (Johnson & Helman 2004). The cost of GP consultations for sore throat was estimated to be £60 million per annum in the UK in the mid-90s, excluding costs of treatment or investigation (Little & Williamson 1996).

Surveys show that patterns of consultation for URTIs vary by demographic and socio-economic indices: children under 5 years of age are the most likely to be taken to a doctor with respiratory symptoms (Hak et al. 2006; Saunders et al. 2003). Morbidity statistics from general practice show that the consultation rate drops from ages 5 to 24, remaining fairly constant from then on (OPCS 1992). Women consult more frequently for all reasons (OPCS 1992) including URTIs (Hak et al. 2006; Morrell et al. 1970).

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[1] These data are old, but the General Practice Morbidity Survey has not been repeated since 1991/2.

Surveys of the experience of symptoms of minor illness suggest that higher consultation rates in women are explained by greater morbidity in women rather than decreased thresholds for consulting (Popay et al. 1993; Wyke et al. 1998). In experimental conditions, women were more likely to develop colds after exposure to viruses, but men who developed colds were more likely to 'over-rate' their symptoms (Macintyre 1993).

Surveys relate socio-economic position to the overall likelihood of consulting, with lower social classes consulting more frequently (Blaxter 1984; Morrell et al. 1970). Canadian adults in larger households, those who had not completed high school, and those who reported not being 'usually happy or interested in life' were twice as likely to consult with URTI symptoms (OR 1.88, CI 1.37-2.57; OR1.92, CI 1.06-3.44; OR 2.47, CI 1.35- 4.52 respectively) (McIsaac et al. 1998)[2]. People with greater numbers of current illnesses or hospital stays and those separated or divorced were more likely to consult with 'trivial' symptoms[3] (Hannay 1980). Contradicting the findings of other studies, the well designed, large survey of McIsaac et al. (1998) found no statistical associations with age, sex, marital status, employment status, urban residence, place of birth, household income, or general health status with consulting a doctor for URTI symptoms (McIsaac et al. 1998).

Prescribing patterns

The UK general practice consultation rate for URTI has fallen since the mid 90s, and the proportion of patients prescribed antibiotics has also fallen (Ashworth et al. 2004; Fleming et al. 2003). Between 1994 and 2000, the consultation rate for acute respiratory infections in the UK fell by 35% (50% for 'common cold') and the proportion of respiratory episodes resulting in an antibiotic prescription fell from 79% to 67% (Ashworth et al. 2004). The pattern is similar in the Netherlands, with a fall in consultation rates for the common cold of about 60%, but with static or slightly higher rates of antibiotic prescription per consultation (Kuyvenhoven et al. 2006).

Surveys show widely disparate antibiotic consumption rates between European Union countries (Cars et al. 2001). Antibiotic consumption in France was twice England's

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[2] Multiple logistic regression involving more than 42,000 people. OR= Odds Ratio; CI= confidence interval

[3] Defined as symptoms not causing pain or disability, and not thought by patients themselves to be serious

consumption and three times higher than in the Netherlands in 2002 (Goossens et al. 2005). Authors speculate that differences may be due to variations in incidence of URTI, differing attitudes to illness, different systems for access to health care, and differences in drug regulation and structure of national pharmaceutical markets (Goossens et al. 2005; van Duijn et al. 2003).

Drawing conclusions from quantitative surveys

Quantitative surveys such as the ones cited in the previous sections can give a broad focus on issues by gathering data on many people and aggregating results. Statistical rigour aims to minimise the effects of chance, bias and confounding (Hennekens & Buring 1987). Some of the URTI survey findings are contradictory (for example, some found that consulting patterns were related to age, gender and marital status, and others did not). These contradictions may be attributable to the fact that different populations were studied, but they may also be attributable to the nature of epidemiological method: techniques such as logistic regression can identify statistical associations between variables, but causal links can only be implied and not proven by this method. Confounding variables can lead to spurious associations and misleading conclusions. In addition, small sample sizes may lead to spurious associations simply by chance. Conclusions can only be drawn about variables that have actually been measured: Fleming et al. provide no evidence for their assertion that reduction in consultation rate is due to decreasing incidence of respiratory infection, since they collected data on consultation rates and not disease incidence (Fleming et al. 2003).

Oakley and others make more profound criticisms of quantitative endeavour (Oakley 1993): statistical method involves standardising experiences which have different meanings to different people and which occur in unique contexts. Surveys use taken-for-granted definitions, or else must impose definitions so that people can answer the question. For example, one person's cold is another person's bronchitis, with very different potential significance (Deschepper et al. 2002). Surveys ask respondents to agree or disagree with statements which lack context, for example 'usually happy or interested in life' will mean very different things to different people, and answers to this question will depend on the circumstances in which it is asked, and respondents' assumptions about the meaning of concepts like 'usually', 'happy', 'life', and also their assumptions about the presumed aims of the research (assumptions about what type of response is desired (Foddy 1994)). This process of decontextualising, imposing researchers' rather than respondents' meanings, and aggregating data leads to

findings which are difficult to interpret (Potter 2001). I critique quantitative consultation research in more detail in chapter 2 (Methodological Journey).

In the light of these reservations about quantitative method, how can quantitative findings about URTI illness and patterns of consulting be interpreted? The findings from surveys which are adequately powered, designed to take account of potential confounding variables and which use variables with more fixed meanings (e.g. age, gender, consultation rates) are likely to be more trustworthy in terms of representing social trends. Judging the quantitative URTI literature on these criteria, it seems well established that respiratory illness is common and mainly self-managed, and that URTI consultations constitute an appreciable proportion of GP workload. Consulting behaviour seems to vary with demographic variables such as age and gender, although findings are contradictory. Prescription of antibiotics varies across time, and between countries. Less convincing are survey claims about correlations with variables such as 'being usually happy or interested in life', because these indices do not have fixed meanings and are difficult or impossible to measure.

This quantitative population-level view conceptualises 'social factors in illness' as fixed socio-demographic variables such as age, gender or nationality: this contrasts with discursive conceptions of 'social position' which I shall explain in chapter 6. Only a minority of those who experience URTIs consult doctors: this raises interesting questions about the reasons for variations in experience of illness, patterns of self-care and decisions to consult. Understanding the meaning of illness helps to explain people's responses to it, and research which explores people's perspectives can address these types of questions. The next section focuses on URTI illness and consultation from the perspectives of doctors and patients, and draws on quantitative and qualitative studies to address questions such as 'How do people with coughs and colds perceive their symptoms?' 'Why do some people go to the doctor and not others?' 'Do patients' perceptions of illness differ from the medical professionals' conceptions of URTI?' 'Why are some people prescribed antibiotics and not others?'

Upper respiratory illness and consultation: a focus on the perspectives of doctors and patients

This section draws on academic literature about URTI, childhood illness and minor illness from the domains of primary care, sociology and anthropology. Quantitative surveys, qualitative interview studies and ethnographic studies explore the meaning of URTI illness to people, their expectations and views of consulting doctors, and doctors' experiences and views in consultation with patients with URTI.

Lay/patients' concepts of URTI illness

Anthropological work suggests that concepts of illness are not static, but are continually adjusted according to particular life circumstances (Hunt et al. 1989). Social and cultural norms influence whether bodily experiences such as headache or running nose are interpreted and responded to as 'illness' or simply seen as part of normal experience (Helman 2000). 'Minor' illnesses such as coughs and colds appear to be on the borderline between being seen as an unexceptional part of normal experience and being labelled and responded to as 'illness' (Zola 1973).

Common respiratory illness was classified as 'normal' by working class East Enders in London studied in the 1980s, in other words seen as not severe and to be expected (Cornwell 1984a). Parents may attribute the symptoms of minor illness in children to normal events such as teething, with parents maintaining conceptions of their children as essentially healthy despite the disruption that illness may cause to a family (Neill 2000). Maintaining this image seems to be linked to parents' self-esteem in their role as parents (Neill 2000).

The 'common cold' does not have a universal definition. For example, in a telephone survey in the USA, the most commonly described symptoms were runny nose, head or nasal congestion, and/or sore throat, but none of these were universally reported (Thumin & Wims 1982). A large range of additional symptoms were also volunteered (headache, fever, watering eyes, body ache, chest congestion, fatigue or weakness and chills). A number of quantitative surveys demonstrate patients' 'misunderstanding' of biomedical models of illness, for example patients' beliefs that antibiotics can treat the common cold (Braun et al. 2000; Shlomo et al. 2003; Wilson et al. 1999).

In an ethnography of common infections including fevers, chills and colds in suburban Londoners in the 1970's, Helman found that concepts of health and illness vary across generations: older people described more personal responsibility for the acquisition of colds than younger people (Helman 1978). For example, older people felt that a cold might be acquired by careless exposure to the environment such as going out with wet hair. Younger people were more likely to attribute colds to germs, viruses or social stress, with individual behaviour being less to blame. Helman links differences across generations to the introduction of the National Health Service and the advent of antibiotics: the younger generation were more likely to give 'medicalised' explanations for illness, and also more likely to seek advice and treatment from doctors. However, lay understandings of causation may differ from medical models, with people often seeing the terms 'bacteria' or 'virus' as synonymous with bug or germ for instance (Helman 1978; Snell et al. 2002).

In Cornwell's ethnography, concepts of health and illness had a close relationship with attitudes to work: East Enders felt that their approach to life and work should be cheerful and stoical, without worrying or complaining (Cornwell 1984a). There were gender differences in response to illness, with men described as 'giving in' to even fairly mild symptoms at home, expecting sympathy and care from women in order to be fit for the next day's work. Women tried to accommodate their symptoms in order to keep going, and readily consulted doctors (Cornwell 1984a). Pill and Stott suggest that concepts of illness causation vary with socio-economic position: Welsh women with less education and who were not home owners were more fatalistic in their beliefs about illness causation and felt less responsible for their own illnesses (Pill & Stott 1982).

A qualitative study set in Belgium and the Netherlands illustrates how labelling and response to symptoms is culturally shaped (Deschepper et al. 2002): Dutch interviewees tended to label respiratory symptoms as 'colds' or 'flu' and responded by nursing their illness at home. In contrast, Belgian interviewees tended to label respiratory symptoms as 'bronchitis' and responded by seeking advice from a doctor.

This mainly ethnographic work shows that definitions and perceptions of illness are social in nature, varying for men, women, older and younger people and across cultural groups. Respiratory infection may frequently not be seen as illness at all, but part of normal experience. The quantitative literature indicated that most people do not consult

doctors for 'minor' symptoms including URTI: the next section examines the reasons that people give for consulting doctors.

Decisions to consult with URTIs

Most people do not consult health professionals with URTI symptoms (Hannay 1980). Patients face contradictions in trying to decide whether to consult. People are encouraged to consult early in the context of cancer or childhood illness such as meningitis, but discouraged from consulting for minor illness (Banks 2000; Kai 1996a; Lau 1987). In a survey in the 1970's in Scotland, 9% reported consulting with symptoms which they said were not painful, did not cause disability, and were not thought to be serious ('trivia') (Hannay 1980). However, 23% had *not* consulted with symptoms which were painful, disabling and which respondents thought were serious.

Decisions to consult with URTIs are not based solely on the nature of the symptoms, but are influenced by many different factors, for example the disruption that an illness causes and the perceived costs and benefits of seeking care[4] (Bennett 1980; Scambler 2003b). In an in-depth qualitative study with the parents of pre-school children, Kai described dilemmas about whether to seek doctors' advice (Kai 1996a): parents found it difficult to decide what was wrong and whether a problem was significant or serious. Sense of responsibility for children's health seems an important motivator for consulting doctors (Pill & Stott 1982) and responsibility to protect their children from harm can over-ride guilt about bothering the doctor (Kai 1996b).

The perceived nature of an illness emerges as an important theme from the literature. Kai found that consultation with acutely ill children was more likely if an illness represented a serious threat (e.g. meningitis, fever, fears of harm such as fits, brain damage or death) and if parents felt that they did not have control over it (e.g. not knowing what to do, worrying about missing something) (Kai 1996b). In a qualitative study of adults, Cornford found that people who had consulted with cough symptoms perceived their symptoms to be more severe, more disruptive, and more worrying than non-consulters with cough (Cornford 1998).

Reasons given by Canadian adults for seeing a doctor for colds and flu included persistence or worsening of symptoms and high fever (Vingilis et al. 1999). In this

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[4] Models such as the Health Beliefs Model attempt to predict and explain health behaviours (Conner & Norman 1996)

survey, self-reported consulting was not related to the accuracy of (biomedical) knowledge about the causes and treatment of colds, but was related instead to poor self-reported health status. The duration of symptoms seems important: people reporting three or more days of limited activity were nearly three times as likely to consult a doctor (OR 2.7, CI 1.41-5.17) (McIsaac et al. 1998).

Surveys report that a proportion of people believe that antibiotics are effective in treating URTIs, and this motivates consultation (e.g. Mainous, III et al. 1997): for example, 70% of American adults felt that antibiotics would be beneficial for bacterial respiratory illness and 55% that antibiotics would be beneficial for viral respiratory illnesses (Wilson et al. 1999). Surveys report that patients believe antibiotics to be more necessary for particular symptoms, for example 63% of respondents thought that antibiotics would be useful for 'green runny nose' (50% for 'loose cough') (Friedman et al. 2003).

Over 80% of adult respondents in a Canadian telephone survey agreed that people should not go to the doctor when they have a cold (Vingilis et al. 1999). However, a medical diagnosis serves to legitimise illness and bypass moral judgments about the culpability of the sufferer (Cornwell 1984a), so the legitimacy lent by medical authority may therefore be an important reason for visits to a doctor (Parsons 1951). For people with sore throat, consulting a doctor was seen as conferring legitimacy on the illness, for example to explain to work or school (60%) or family or friends (37%) (Little et al. 1997b).

Attitudes towards consulting a doctor differ in different cultural groups: Belgian respondents reported a greater need to consult with respiratory symptoms than British or Dutch respondents, considering respiratory symptoms to be more serious, less self-limiting, and antibiotic treatment more necessary for recovery (van Duijn et al. 2003). Consulting doctors and taking antibiotics were seen by Belgian respondents as responsible behaviour in the face of uncertainty about the illness, fear of complications and a wish to return to work. Differences in attitudes between Dutch and Belgians were linked by the authors to religious differences, and to structural differences in access to health care (Deschepper et al. 2002). Perceptions about the need to see a doctor seem to be changing: a Dutch survey suggests that people were less likely to think that seeing a GP for self-limiting illness was appropriate in 2001 than in 1987 (Cardol 2005).

National Health Services are free in the UK and patients can, in principle, choose whether and when to consult. However, the structure of services has an influence on access and demand for health care, for example through the structure of an appointment system (Murray & Berwick 2003). Patients' past experiences of health services will also influence future service use. For example, receiving an antibiotic prescription seems to encourage future consultation with URTI (Little et al. 1997a). In contrast, frustrated past experience serves to discourage future consulting (Rogers & Nicolaas 1998). Prescriptions are free to particular groups of patients in the UK (e.g. under 16s or over 60s, those on income support or with certain chronic diseases): a small proportion (6%) of 'inappropriate attenders' in one UK survey had consulted to obtain a free prescription (Hammond et al. 2004).

Consultation rates for URTI and the proportion prescribed antibiotics has fallen since the mid-1990s in the UK: changes in health service provision and policy initiatives to reduce antibiotic prescribing have coincided, and it is difficult to know whether these factors are responsible for the fall (see chapter 4 'Setting the Scene', for discussion of the UK policy context).

Decisions to consult are influenced by many factors (Mechanic 1978). The perceived severity of symptoms, disruption to normal activities and beliefs about appropriate treatment are identified in the URTI literature as important motivators to consult doctors, and these are socially and culturally defined. The structure of health services and patients' past experiences also seem important. Whilst visits to the doctor seem to depend upon the nature of symptoms as much as on social factors such as disruption to normal role, the previous section showed that interpretations of symptoms are themselves profoundly socially determined. The next section examines URTI consultations from a lay/patient perspective.

Patients' concerns and expectations in URTI consultations

Post-consultation interviews with patients reveal that concerns may not be disclosed to doctors (Barry et al. 2000). Adults with coughs raised worries about potential lung damage or strain on the heart in interviews, but these worries were rarely shared with doctors, or even with relatives (Cornford 1998). The mothers of children with 'chesty' coughs often did not tell doctors about their worries, feeling that their concerns would seem foolish (coughs were seen as dangerous due to development of long term damage such as asthma, choking on phlegm or vomit or death from sudden infant

death syndrome) (Cornford et al. 1993). In a Finnish primary care study, patients hesitated to disclose their models of illness to doctors, giving reasons such as respect for authority, fear of hurting the doctor's feelings, disbelief that a doctor is genuinely interested, or feeling that it is the doctor's job and not theirs to diagnose what is wrong (Punamaki & Kokko 1995).

Patients' worries may not be disclosed in consultation, and similarly hopes or expectations for advice or treatment may not be mentioned either (Barry et al. 2000): in a UK qualitative study, patients seldom made their expectations explicit in consultations for respiratory symptoms, and expectations were often not met (Butler 1998b).

Although a proportion of patients do want antibiotics (see previous section), some patients may be given antibiotic prescriptions which they were not expecting. Patients report wanting reassurance, further information, and pain relief instead of antibiotics (Kallestrup & Bro 2003; Neill 2000). Parents of ill children may also consult to avoid complications, have their child examined (Shlomo 2003) and to get a diagnosis (Sanchez-Menegay et al. 1992). The parents of pre-school children in the UK wanted reassurance that they had taken all necessary steps to care for their child, and had not missed anything serious (Kai 1996a; Neill 2000). They also wanted specific and practical information about likely causes of acute illness, when to seek advice, how to assess severity, how medicines work, and how to prevent future illness (Kai 1996a).

Interview studies point to difficulties for patients: for example, parents said that they were wary of questioning a doctor's authority in consultation, and were often left feeling silly for worrying or still perplexed by a problem if their concerns were not addressed. Lack of information and explanation from doctors felt disempowering (Kai 1996a). Patients interviewed in Finland felt that health carers should treat them as individuals who are experts about their own illnesses, rather than giving advice based on knowledge of an 'average' course of illness (Punamaki & Kokko 1995). Whilst patients may have a variety of expectations in consultation, a prescription of antibiotics may be seen by patients as a symbol that their concerns are taken seriously, and as a way of helping people cope with illness (Kai 1996a).

Quantitative surveys have sought to identify which elements of doctors' behaviour may be correlated with patient satisfaction, although satisfaction is a very difficult concept to define and measure since it depends upon initial expectations (Newsome & Wright 1999). In one study, satisfaction was related to degree of personal interest and reassurance, and whether patients felt they had received the right medication

(Sanchez-Menegay et al. 1992). In another study, satisfaction with consultations was strongly correlated with factors such as how well the doctor dealt with patients' concerns rather than to the prescription of antibiotics (Hamm et al. 1996), and patients who were more satisfied got better more quickly (Little et al. 1997b).

In summary, whilst antibiotics feature on patients' agendas, their needs in consultation are more complex and may include hopes of other types of prescription, explanation and reassurance. The nature of the doctor-patient interaction seems important to patients. It seems odd that people may avoid mentioning worries about their symptoms or their expectations for treatment in consultation: there are hints that this may be due to preservation of 'face' (e.g. worries about seeming foolish) and/or wariness about questioning doctors' authority. Not mentioning worries or expectations seems to undermine the apparent purpose of consulting and this raises questions about what actually happens in consultations and how doctor-patient interaction can lead to these outcomes. I shall now turn to doctors' views of respiratory illness, of patients and of URTI consultations.

Doctors' views of URTI illness

Patients label and interpret respiratory illness in socially determined ways, and doctors also do (Stein 1986). Using clinical vignettes, Stocks and Fahey found that doctors in the UK used different combinations of signs and symptoms to define URTI and other respiratory illness (Stocks & Fahey 2002). For example, doctors did not agree on the clinical features defining bronchitis or lower respiratory tract infection.

Stein suggests that explanatory models for illness used by doctors in practice may be quite different from textbook biomedical models. In practice, a physician's explanatory model may be influenced by their own/family models for sickness behaviour, emotional factors, the influence of a particular specialty, the institutional setting (e.g. emergency, outpatients), the extent of pressure to produce a diagnosis and the perceived character or type of patient as well as the symptoms presented (Stein 1986). Stivers found that doctors were more likely to give a bacterial diagnosis to acute respiratory symptoms when they thought that parents expected an antibiotic (Stivers et al. 2003).

Helman's ethnography of coughs, colds and fevers suggests that there is a blurred boundary between folk beliefs and the models of illness used by doctors in clinical practice. General practitioners used folk idioms such as 'you've picked up a germ'

rather than more precise medical diagnoses. He suggests that doctors were not overly concerned about accurate biomedical labelling for a condition which is self-limiting and trivial, and in fact more precise diagnoses are not possible technologically or in a time-limited consultation (Helman 1978). Doctors also seem to draw upon folk ideas in the prescription of treatments such as cough mixture to 'flush out' infection (Johnson & Helman 2004). Helman suggests that doctors' drawing on folk idioms may have the effect of reinforcing these ideas, for example blurring the distinction between bacteria and viruses, and confusing the issue of the appropriateness of antibiotic prescribing.

In summary, the evidence about doctors' conception of URTI illness is rather limited in comparison to richer ethnographic study of lay models. It seems that doctors' labels for URTI illness and the models they draw on are fluid, and overlap with lay models. Assigning a diagnosis is assumed to be the result of objective clinical assessment (Cameron 2002) but instead may be somewhat arbitrary and flexible and sometimes chosen to rationalise treatment decisions (Stivers et al. 2003).

Doctors' views of patients with URTIs

There is a long-standing discourse about the appropriateness of consultation for URTIs and other self-limiting conditions in primary care literature (Morrell et al. 1980). For example, general practitioners surveyed in 1981 felt that half or more of their consultations were for trivial, unnecessary or inappropriate reasons (Cartwright & Anderson 1981). 'Inappropriate attendance' can be seen as illegitimate access to a sick role (Parsons 1951). In Parsons' functionalist model (which has been much refined and critiqued (Morgan 2003)), a sick role allows people to shed normal activities and responsibilities and to be cared for. A sick person should, in return, seek medical advice and co-operate in order to get well as quickly as possible. Doctors in Parsons' model have a professional duty to act for the welfare of the patient and community, and they play a role in legitimising illness, acting as gatekeeper to the sick role in determining who is to be given the privileges of the role and who is not (Bury 1997). I critique this Parsonian model of 'role' in chapter 2, but the model is a useful way of conceptualising consulting as an event with wider social significance.

Consultation for URTI makes up a large proportion of work that is viewed by the medical profession as inappropriate: 86% of GPs in a UK survey in 1999 felt that they were consulted about minor illness either 'often' or very often', with URTIs making up 75% of ailments classified by them as minor (Morris et al. 2001). Eighty-nine percent of

GPs agreed that 'People should rely less on GPs and more on their own common sense regarding minor illness health problems' and 78% agreed that 'People today consult their GP far too early in their illness course'. Contrary to the portrayal of URTI as a prelude to a hidden agenda, 61% of GPs in this survey did not feel that 'minor symptoms are frequently used as a pretext for a more serious, unrelated problem' (Morris et al. 2001).

The primary care literature often links GP frustration or burn-out with consultations for 'trivial' reasons: in a UK survey in the 1990s, 45% of London GPs reported often feeling exhausted, with 46% often feeling frustrated by trivial consultations, and a third seriously disenchanted with work (Grieve 1997). A different UK survey found that more than half of GPs (55%) felt that patients consulting for URTIs lacked self-reliance (Butler 1994). In a qualitative study, doctors often saw URTI consultations as mundane and time consuming, with the potential to generate disagreements (Kumar et al. 2003). Marsh suggests a number of reasons why consultation for minor illness may irritate general practitioners (Marsh 1977): these relate to ideas about appropriate work for a doctor e.g. that treatment of more major conditions is more of a priority, a feeling that skills and knowledge are being under-used and that less highly trained workers could look after minor illness.

Doctors also reported redeeming features of URTI consultations: whilst 60% of general practitioners in the UK agreed that 'I often feel frustrated by the proportion of my work that consists of seeing patients for minor illness health problems', 55% also felt that 'Minor illness consultations help to dilute the more demanding consultations and balance my working day' and 57% felt that 'I would rather see a patient for a minor illness consultation than risk missing something of potential importance' (Morris et al. 2001). URTI consultations can also be seen as an opportunity to build rapport, and as a welcome break in an otherwise stressful surgery (Butler 1994).

Surveys suggest that GPs' perceptions of patients vary with demographic characteristics of patients: calls about URTIs and about prescriptions were the most frequent reasons for calling a US out-of-hours call centre (John & Curtis 1988) and physicians felt more anger or frustration with frequent callers, with adults (rather than children) and with black women.

Jeffery's ethnographic work in three casualty departments in the UK outlined the way in which doctors regulate access to the sick role by making moral assessments of people. Patients who were not seen as having legitimate illness were treated with hostility by

staff (Jeffery 1979). 'Good' patients were those with medical conditions which allowed staff to practise their skills (for example heart attack or road accident victim). 'Bad' patients were those who had broken unwritten rules about the type of condition or type of person seen as legitimate work for casualty staff. Bad patients included 'drunks' 'overdoses' 'tramps' and those with trivial complaints defined as 'conditions which any reasonable person could have made up their own mind about' (Jeffery 1979). Staff were uncertain about the existence of an illness if there was no therapy which could be provided. Legitimate illness was seen as that which restricts normal activities; this rule was broken by those with trivial complaints who had been able to delay coming to casualty. Those with trivia were suspected of malingering, in other words wanting the benefits of a sick role and breaking the unwritten rule that patients should see illness as an undesirable state (Jeffery 1979).

Moral judgments were made by casualty staff about patients (Jeffery 1979). 'Bad' patients were given derogatory labels ('rubbish', 'crumble', 'grot', 'dross', or 'dregs') if they or their illness were judged illegitimate, and punished in a variety of ways: treatment could be delayed, and hostility or no sympathy shown (Stein 1986). Patients may be branded negatively if they are held responsible for their own illness or if they refuse to be independent or co-operative. Doctors may stereotype patients and evaluate patients morally on criteria such as whether they are judged hard-working or not. Mechanic and Volkart suggest that students consulting with 'common, familiar, predictable, and generally non-dangerous illness' had a lower threshold for adopting a sick role and consulting a doctor (Mechanic & Volkart 1960).

The way that health care is organised and financed may influence doctors' categorisation of patients and the rationing of care: for example minor complaints were often seen as inappropriate work for an emergency department in France (Vassy 2001). Decisions about redirecting patients to general practitioners were made on an individual basis and the outcome was variable depending upon the attitudes of different staff members, the volume of work to be done, time of day (e.g. for availability of particular clinics) and factors such as judgments about a patient's ability to pay for alternative services.

In summary, quantitative surveys of doctors' opinions give a rather limited insight into doctors' perceptions of patients, since questionnaires force choices from pre-defined options. However, the qualitative ethnographic work in casualty departments suggests that doctors make judgements about illness and patients which are bound up with personal characteristics of patients and the circumstances of their attendance. Doctors'

negative views of minor illness and moral judgements of patients are important themes in URTI consultations: I explore these further in chapters 4 and 6.

Doctors' tasks in URTI consultations

Making a diagnosis

It can be difficult for doctors to be sure of the diagnosis with acute respiratory symptoms (Morrell 1972). For example, doctors cannot easily distinguish clinically between viral and bacterial infection, between bronchitis and pneumonia, or upper and lower respiratory tract infections (Coenen et al. 2000). It is difficult to be certain that a symptom really represents a minor problem: ill-defined symptoms may be the fore-runner of serious illness such as insidious cancer (Lau 1987) and/or a patient's mention of minor symptoms may be a prelude to a psycho-social 'hidden agenda' (Balint 1957). Doctors' responses to apparently minor symptoms vary with the context for consultation, for example symptoms may be taken more seriously if the patient is someone who does not normally consult (Lau 1987).

Antibiotic prescribing

Evidence from randomised controlled trials suggests that antibiotics are not effective treatments for sore throat (Little et al. 1997b) acute respiratory illness in children (Fahey et al. 1998b) or cough in adults (Fahey et al. 1998a). Increasing bacterial resistance to antibiotics is blamed mainly on prescribing patterns in primary care: a large proportion of total prescribing is for respiratory infections (Department of Health 2002; Subgroup of Antimicrobial Resistance & DOH 1998). Guidelines recommend that antibiotics are avoided if 'not clinically necessary' (SIGN 1999) and there are national initiatives in the UK and internationally to encourage doctors to change their prescribing habits (Department of Health 2002) (see chapter 4 (Setting the Scene) for discussion of UK antibiotic policy). Antibiotic prescribing rates vary widely between practitioners (Kuyvenhoven et al. 1993): quantitative and qualitative research has explored reasons for variable prescribing rates, to try to explain behaviour which seems counter to evidence-based, rational decision-making (Butler et al. 1998a):

Qualitative studies indicate that general practitioners are uncertain which patients will benefit from antibiotics but make judgments on the basis of patients' socio-economic background and because of concerns about medical complications (Howie 1976; Kumar et al. 2003). Doctors say that they fear medico-legal repercussions if patients deteriorate and feel that possible benefit for a particular patient outweighs theoretical

risk to the community from resistant bacteria (Butler 1998b). Missing a diagnosis or under-treating seems more of a concern for doctors than over-prescribing antibiotics (Coenen et al. 2000; Snell et al. 2002). Coenen et al. suggest that treatment decisions may be made first and then diagnoses follow as a justification for the therapeutic decision (Coenen et al. 2000). This study suggests that treatment decisions are more likely to be made on the basis of factors such as patient expectations, time pressure, a doctor's past experience or fear of losing patients than on clinical grounds.

Bradley found that decisions that involve respiratory illness and antibiotic prescribing may frequently be uncomfortable for doctors (Bradley 1992). GPs may be more likely to prescribe all types of medication if they think that patients want a prescription (Britten & Ukoumunne 1997; Cockburn & Pit 1997). Doctors describe pressure from patients for antibiotics (Bradley 1992; Howie 1983), prescribing even if they feel that antibiotics are not clinically necessary (Coenen et al. 2006; Macfarlane et al. 1997). Doctors may misjudge and overestimate patients' expectations for antibiotics (Cockburn & Pitt 1997) and may assume that patients want antibiotics instead of self-care (Virji & Britten 1991).

In qualitative studies, doctors report being more likely to prescribe in pressured clinical contexts (Howie 1983; Kumar et al. 2003) and admit that they sometimes do not have the energy to resist demand from patients although they acknowledged that this probably increases workload in the long term (Butler 1998b). One qualitative study suggested that doctors prescribe in order to maintain good relationships with patients (Butler 1998b) although this finding was not confirmed in another qualitative study (Kumar et al. 2003). Doctors said that they did not want to be perceived as having done nothing for patients (Butler 1998b).

Doctors therefore seem to face dilemmas in URTI consultations, firstly in being sure of the diagnosis, and secondly balancing potential benefit of antibiotic treatment to individual patients against the harms of bacterial resistance to antibiotics. The literature describes the way that doctors' decisions deviate from being 'evidence-based': doctors make judgements about the socio-economic position of patients, and respond to patient expectations for antibiotics. There is a suggestion that doctors are also concerned about how they are perceived by patients and did not want to be seen to have done nothing: I will analyse how doctors' advice and prescribing is related to their identity as doctors in chapter 6.

Summary: doctor and patient perspectives

The literature which explores URTI illness and consultation from the perspectives of patients and doctors starts to address some of the questions raised by the quantitative literature on URTI, for example reasons for variation in patients' responses to illness and for doctors' apparently irrational prescribing behaviour. Central to understanding these apparent paradoxes is understanding the meaning of things to people (Murphy et al. 1998). Illness itself has social meaning for both doctors and patients, and doctors' and patients' models of illness seem fluid and overlapping. Responses to illness are variable and deeply shaped by social and cultural factors, again for both doctors and patients. People's behaviour invokes moral evaluations, and 'minor' illness seems to be particularly morally ambiguous since URTI symptoms lie on the boundary between normal experience and abnormal (i.e. 'illness'). Contested legitimacy of consulting for upper respiratory illness and contested treatment (with antibiotics) means that the aim of the doctor-patient interaction and expectations of each other may need to be more carefully negotiated in URTI consultations than in consultations with a more clearly 'medical' focus (Hamilton 2004). The way that potential conflicts are managed without loss of face on either side is likely to be analytically interesting (Gwyn 2003d): I take up these themes in chapters 4,5 and 6.

As in the population-level studies (see page 20), 'social and cultural factors' are defined as demographic variables in the patient and doctor perspective literature, but with an emphasis on the way that these variables can shape the meaning of events to individuals. Interesting questions emerge from this literature, for example: How it is that patients do not disclose their concerns or expectations to doctors? What happens in consultation if patients and doctors have different interpretations of the meaning of symptoms and/or the legitimacy of consulting? Why do doctors choose particular diagnoses, and can diagnoses be contested by patients? How are differing expectations for antibiotics negotiated in consultation? Quantitative surveys or qualitative interview-based studies can give only limited insight into these types of questions: in chapter 2, I critique these approaches to researching doctor-patient consultations and take up the proposition that a deeper understanding of consultations means studying consultations themselves.

The next chapter charts my methodological journey from quantitative approaches to my discovery of discourse analysis.

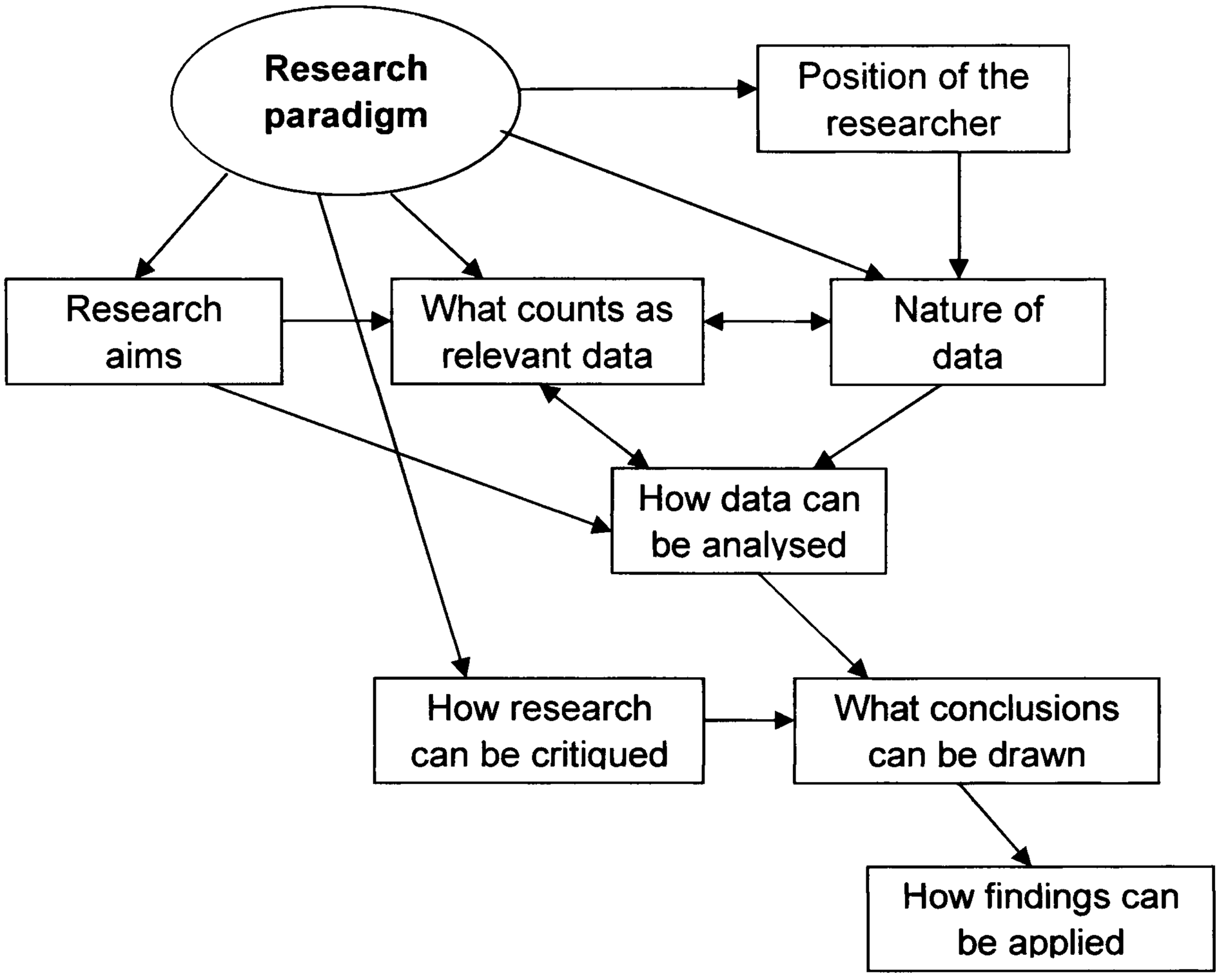
Chapter 2-
A methodological journey: discovering discourse analysis

This chapter continues my account of how this research came about, representing a methodological journey through different research paradigms. I start with a quantitative, positivist paradigm, then discuss constructionist qualitative approaches, and then explore the discursive perspectives which underpin this thesis. I discuss concepts of social construction, face and identity, and explore how these ideas are relevant for understanding URTI consultations.

Research paradigms

Research paradigms are philosophical approaches, comprising assumptions and beliefs about the nature of the world (ontology), the nature and grounds of knowledge (epistemology) and assumptions about appropriate approaches and techniques for enquiry (methodology) (Guba & Lincoln 1994). Choice of research paradigm informs the aims of research endeavour, what counts as relevant information, the nature of data, what position the researcher holds in relation to the research participants and the data, how data can be analysed, what conclusions can be drawn, how certain knowledge can be, how quality can be judged, and how findings can be applied (Spencer et al. 2003) (see Figure 1).

Figure 1. Domains of assumption underlying research paradigms



I use this framework to think about the assumptions underlying quantitative and qualitative social research, illustrating these by describing two typical studies from the URTI literature (one positivist, one constructionist). I critique these approaches and explain the philosophical assumptions which underpin two discursive constructionist approaches: conversation analysis and discourse analysis[5].

[5] In this thesis I have used the term 'discourse approach' to embrace a variety of methodological approaches, and the terms conversation analysis (CA) and discourse analysis (DA) to mean specific approaches to analysis.

Critique of positivist, quantitative social research

All research is underpinned by ontological and epistemological philosophical assumptions, although the assumptions underpinning medical science are so taken-for-granted that they are usually not explicitly acknowledged by researchers (Gordon 1988). Most published research in primary care is quantitative, and most accords with a positivist philosophy (Guba & Lincoln 1994). Positivism takes it for granted that the social world can be investigated through objective fact-gathering, and that statistical method yields the most objective, reliable and valid data. I shall illustrate the assumptions which underpin a positivist paradigm for social science by describing a survey of doctor and patient views.

'Doctors' and patients' views on respiratory tract symptoms'

A fairly typical example of a quantitative survey of views from the URTI literature is that by van Duijn and colleagues (van Duijn et al. 2002) (see chapter 1), published in the Scandinavian Journal of Primary Health Care in 2002[6]. The authors administered a questionnaire to 51 patients, 38 members of the public and 7 doctors, aiming to find out whether there were differences between doctors' and patients' views on respiratory tract symptoms. The patients (who had respiratory symptoms) were given a six item questionnaire; doctors and members of the public (who were not symptomatic) received an 11 item questionnaire. Respondents were asked to agree or disagree with statements such as the following, using a five point Likert scale:

'Sore throat almost always gets better without treatment within 1 week'
'If a sore throat lasts longer than 1 week, it is advisable to see a doctor'
'You need antibiotics if you have a sore throat with a raised temperature'
'Cold and cold air are important causes of conditions such as cough, sore throat and earache'
'Bacteria are an important cause of conditions such as cough, sore throat and earache'

The authors found differences in responses from doctors and patients (although the study was too small to find statistically significant differences).

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[6] http://taylorandfrancis.metapress.com/media/pf9dmxgvtmdqynbhfj6u/contributions/1/v/m/t/1vmtv915arvumc0l.pdf

This work by van Duijn et al. is consistent with a positivist philosophical paradigm (Guba & Lincoln 1994). With reference to figure 1, the aim of the research was to quantify differences in opinion. The researchers transformed respondents' responses (their opinions) into numerical data for statistical analysis. The paper is written in passive tenses (e.g. 'a questionnaire was constructed'), which positions the researcher as an objective observer, gathering data and simply describing what is there to be found. Quantifying responses implies that statements have fixed and universal meanings; this assumption is often reflected in the procedures for validating questionnaires (to try and fix agreed meanings) and checks of reliability (to check that responses are consistent). This model of social research does not see any problems with simply inquiring about phenomena such as beliefs, attitudes or feelings (as long as respondents are truthful in their responses), assuming a Saussurean model of language; in other words that language is a vehicle for expressing underlying reality (Kress 2001). Discursive approaches conceptualise language quite differently: I shall discuss these differences in later sections of this chapter.

As mentioned in chapter 1, quantitative social research involves standardisation into numerical categories and abstraction from the original context in which responses were made (Oakley 1993). Standardised questions may be difficult for respondents to answer because the statements are general and abstract and answers depend upon assumptions about what it is that the researcher is trying to ask. To take the first statement quoted above, there may be many differences in assumptions about what is meant: for example patients and doctors may define 'sore throat' differently; a patient with the symptoms of sore throat may feel that other people's sore throats generally get better within a week, but that their own experience of sore throat is different; respondents have to guess what the researchers mean by 'treatment': does this include bed rest, hot drinks or paracetamol or does this refer only to prescribed treatment ? (and so on). In other words, a questionnaire assumes shared meaning for statements, but there may be significant differences in interpretation which a tick-box survey would not detect. Although the same questions are asked of all respondents, they will be interpreted in unique ways by different people, with underlying assumptions remaining invisible to researchers (Potter 2001).

The 5 point Likert scale used for responses in van Duijn's study is arbitrary and abstract, for example, how do respondents decide whether they 'agree' or 'strongly agree' with a statement such as *'Cold and cold air are important causes of conditions such as cough, sore throat and earache' ?* This process assigns an arbitrary quantitative score to statements, and since it is not known what assumptions

respondents make in answering this question, nor how one can quantify something like 'strength of agreement', summing the scores and comparing between people means that the study findings have only a tenuous link with respondents' experiences and perceptions.

Surveys with a fixed choice of responses reflect the researchers' concepts, language and agendas rather than exploring those of respondents: van Duijn et al. investigate the link between respondents' beliefs about the effectiveness of antibiotics and decision to consult doctors, uncritically assuming that consulting with URTIs is inappropriate and motivated by misunderstandings about the nature of self-limiting symptoms and the effectiveness of antibiotics. The study uses biomedical concepts e.g. 'bacteria', and does not allow exploration of respondents' priorities or conceptual systems. Qualitative approaches represent a challenge to the assumptions within positivist paradigms (Murphy et al. 1998) and I shall explore these in the next section.

Assumptions within qualitative methodological approaches

Qualitative approaches are often compared and contrasted with quantitative (Pope & Mays 2000). However, 'qualitative' and 'quantitative' are methodological approaches (specifying the type of data to be analysed as numerical or not) rather than philosophical paradigms. There is, however, some correspondence between approach and philosophical paradigm in that qualitative approaches tend to challenge positivist assumptions about ontology, epistemology and methodology (Murphy et al. 1998).

The term 'qualitative methodology' embraces a wide range of approaches and methods derived from many different traditions of social research (e.g. philosophy, sociology, anthropology, linguistics, psychology, education, cultural studies). Murphy et al. give a detailed overview of the historical influences and debates which shape approaches to qualitative research (Murphy et al. 1998). Much primary care research was (and still is) in the form of quantitative surveys of opinion, but qualitative research is gaining increasing recognition (Britten 2005). There is no clear consensus about the philosophical underpinnings for qualitative research, and this manifests in ongoing debates about how qualitative research should be conducted and presented (Blaxter 2000; Yardley 2000).

As with quantitative research, underlying philosophical approaches are not often made explicit in qualitative work. However, whilst the value of a positivist approach is taken-for-granted and therefore does not need to be stated in quantitative work, the paradigms underlying qualitative research may be obscured for other reasons: researchers using qualitative approaches face dilemmas about how to present their work, since it may be judged using the criteria applicable to quantitative, positivist paradigms rather than on its own terms (Blaxter 2000). This leads to researchers presenting their work to accord with positivist paradigms in order for it to be publishable, and this probably adds to confusion about underlying philosophical approaches in qualitative work.

A qualitative study won the Royal College of General Practitioners/Boots Research Paper of the Year award in 1996, and I have chosen this paper to illustrate the assumptions which underlie a qualitative approach (Kai 1996b). Kai does not explicitly name his philosophical approach, but his work is consistent with a 'weak' (rather than radical) social constructionist paradigm (Burr 2004) which is fairly typical of qualitative approaches in medicine (Pope & Mays 2000). I shall describe this study in some detail to illustrate advantages of qualitative approaches in social research, referring to figure 1 to illustrate underlying methodological assumptions.

'What worries parents when their children are acutely ill?'

Kai's research is an in-depth qualitative study published in the British Medical Journal in 1996 (which I cited in chapter 1) (Kai 1996b). He carried out interviews and focus groups with 95 parents, and used a grounded theory methodology to generate a model for how parents perceive and cope with a child's illness[7].

In contrast to quantitative survey methods, qualitative approaches are appropriate for researching subjective phenomena such as understandings and perspectives (for example parents' views in Kai's study), since concepts and meanings can be explored (Britten et al. 1995). Qualitative research can be more 'patient-centred', encouraging exploration of respondent definitions and priorities rather than a purely researcher-defined agenda (Britten et al. 1995): a semi-structured topic guide (common in interview-based research) allows discussion of researchers' and respondents' agendas (Pope & Mays 2000). Qualitative approaches allow for a flexible and emergent research design, encouraging changes of direction with unexpected findings rather

[7] http://bmj.bmjjournals.com/cgi/content/full/313/7063/983

than adhering to a pre-defined research agenda (Murphy & Mattson 1992). Both the methods for data collection (e.g. the direction of individual interviews) and the overall design of the project can be changed to pursue fruitful avenues.

Research Aims

Kai's aim is to identify and explore parents' concerns and perceptions about children's acute illnesses. He systematically codes and categorises data to build up theoretical models which are grounded in the data (Strauss & Corbin 1998), generating a model for how the perceived threat of an illness is balanced against parents' (mostly mothers') sense of control over the illness. Particular scenarios represented more threat (e.g. meningitis, asthma) and sharing responsibility was a way of increasing control and decreasing the threat of illness. The aim of Kai's research is therefore to explore the meaning of childhood illness for parents, and to generate theoretical models to deepen understanding of phenomena. Theory is necessarily abstract (Morse 1997b) but grounded theory methodology aims to generate theory which remains 'grounded' in data (i.e. arising from and close to the data) (Heath & Cowley 2004; Strauss & Corbin 1998).

What counts as relevant data

Kai uses purposive sampling (Patton 1990), selecting a diverse range of participants including those with atypical experiences, in contrast to quantitative random sampling which aims to select a typical sample of a population. The data in Kai's sample are transcripts of audio-taped interviews and focus groups. He reports no quantitative data except response rates and demographic characteristics of participants; the research findings are qualitative summaries of respondents' ideas, and a theoretical model generated from these.

Subjects or texts are sampled in qualitative research for their ability to illuminate a particular problem, rather than to statistically represent a wider population. In contrast to the large sample sizes needed in quantitative research, qualitative approaches aim to explore phenomena in depth and in detail with a small sample (Murphy et al. 1998; Pope & Mays 2000). Qualitative approaches can account for 'deviant' cases which might simply be counted as statistical anomalies in quantitative research (Morse 1997b).

Position of researcher

Social constructionism holds that the researcher cannot escape the social world in order to study it, in other words a researcher also brings his or her perspective as a member of society (Mauthner & Doucet 2003). Social research is seen as an interpretative process, rather than the objective discovery of social facts, and a researcher is seen as active in shaping knowledge or ideas (Murphy et al. 1998). A constructionist paradigm acknowledges the social nature of the research process, acknowledging that the researcher's social position (e.g. age, gender, ethnicity) and the context of data collection (e.g. location of interview, how study was introduced) influences the gathering of data and its interpretation.

Kai acknowledges that his social position is likely to have influenced the resultant data: he describes himself as a male middle class health professional, and the respondents as mostly women from disadvantaged backgrounds. This conceptualises social position in terms of fixed demographic variables which contrasts with a discursive conception which I will discuss in later sections of this chapter.

Nature of the data

Parents' concerns and perceptions are 'subjective' in that they cannot be observed or measured. Qualitative approaches are well equipped to illuminate subjective phenomena such as meanings, rather than seeing these as either un-researchable or unreliable (Stevenson et al. 2000). Qualitative approaches allow the complexity of social phenomena to be explored in a holistic and naturalistic way (Murphy et al. 1998). Constructionism understands phenomena such as people's views, beliefs and behaviour to be social constructions, in other words socially agreed and sustained, and specific to particular cultures and time in history (Burr 2004). However, despite being social constructions, 'weak' social constructionists hold that views, beliefs etc can still provide information about the phenomenon to which they refer (Spencer et al. 2003).

Consistent with a 'weak' social constructionist position, Kai reports respondents' views in a literal way, for example *'Fever, cough and the possibility of meningitis emerged as parents' primary concerns when their children became acutely ill'* (Kai 1996b). Kai presents his findings as probably a partial picture (a public, socially acceptable account influenced by his social position as a male, middle class doctor) but nevertheless as representing parents' thoughts, feelings and opinions.

How research can be critiqued

Constructionist paradigms assert that 'reality' can be represented from a range of different perspectives (Burr 2004). Kai draws upon concepts of respondent validation to check his description of the data and make sure that his interpretations were 'true to respondents' experiences' (Kai 1996b). In a constructivist paradigm, researcher's interpretations may well be different to those of respondents, since their perspectives are different, but Kai did not seem to encounter this potential problem with respondent validation (Sandelowski 2006). There is debate about which criteria are suitable for evaluating qualitative research: I discuss this in chapter 7.

Summary

I have critiqued positivist, quantitative approaches to social research, and pointed to the advantages of qualitative approaches for social research, using Kai's study as an example. Kai has used interview data to provide insight into mothers' social reality: discursive approaches challenge the idea that language can be treated as straightforwardly representing 'reality'. In the next sections, I shall explore the ideas which underpin qualitative discourse approaches, in particular conversation analysis and discourse analysis which are the main approaches I draw upon in this thesis.

Discourse approaches

Within the social sciences there has been a radical shift in ideas about how language can be understood (for example, summarised in (Jaworski & Coupland 1999; Potter & Wetherell 1987)). Before this 'linguistic turn' in the 20th Century, it was assumed that the real world, a person describing this world, and the language they use to represent the world are all separate from each other (Kress 2001). Language was seen as a method for representing reality in a more or less faithful way (Wetherell 2001b). With the linguistic turn, a dynamic relationship between these three elements is proposed, in other words that 'reality' comes into being through the meaning people ascribe to things rather than the inherent properties of things (Wittgenstein 1953): the way that language is used *creates* the meaning which is ascribed to things rather than simply describing what is already known. Language is therefore seen as constituting rather than simply reflecting reality (Burger & Luckman 1966; Horton-Salway 2001).

Another realisation about language is that it is not simply a neutral medium for describing things, but that its use achieves social actions (Austin 1962; Cicourel 1974;

Garfinkel 1967). For example, at a micro level, language achieves the split second co-ordination regulating turns in talk (Sacks et al. 1974). On an intermediate level, social identities such as 'mother' 'woman' 'patient' are negotiated through language (de Fina et al. 2006). On a macro level, the transactions of society's institutions are mediated through language (e.g. law, medicine, business, education) (Fisher & Dundas Todd 1986; Foucault 1973) and language constitutes ideologies such as discourses about race or gender for example (Hall 2001). These two concepts (firstly that language constitutes social reality rather than simply reflecting it and secondly that language can be seen as social action) are central in discourse approaches, and I shall explain in more detail in later sections of this chapter how these ideas relate to doctor-patient interaction.

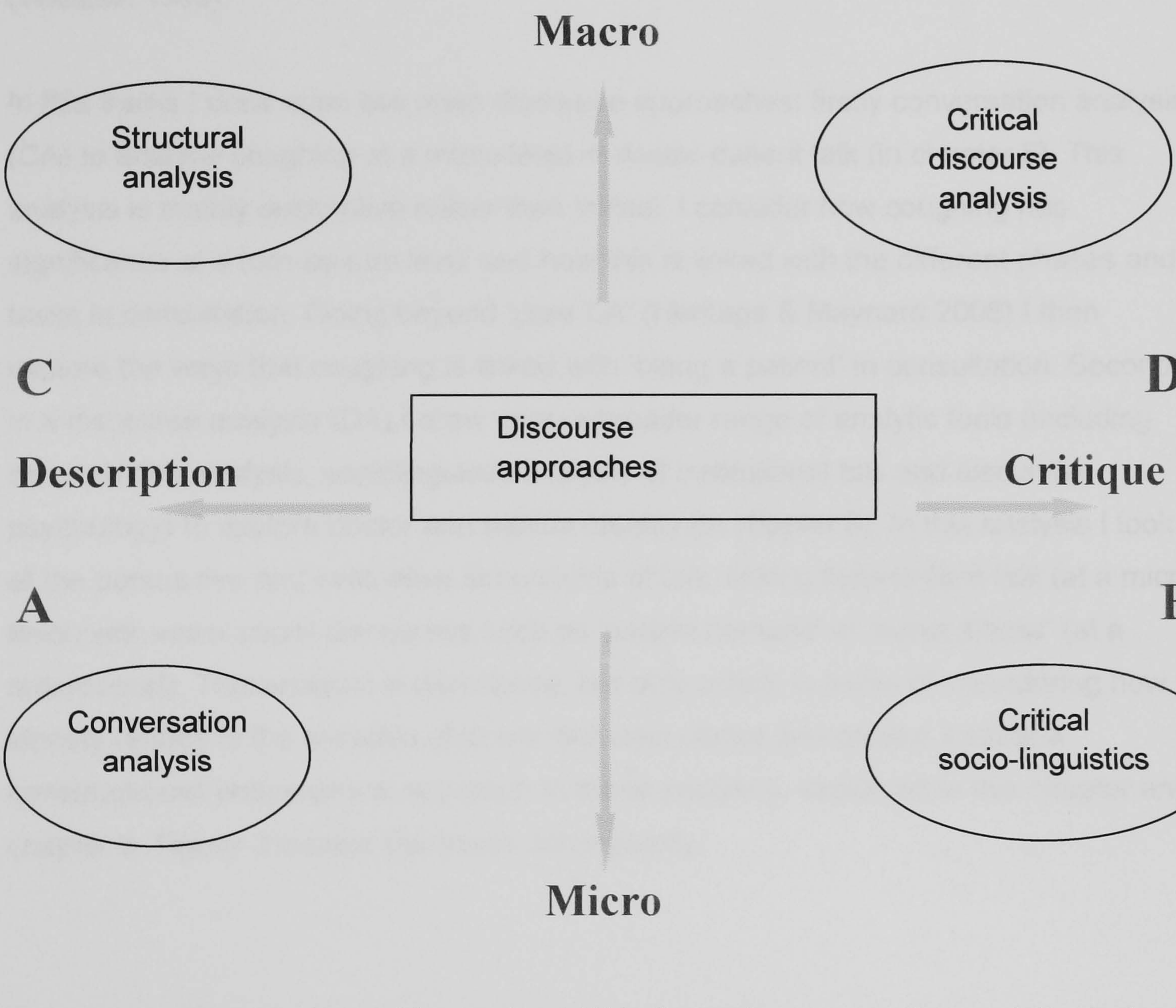
Discursive approaches derive from many different academic traditions, particularly philosophy of language, anthropology, linguistics, psychology, cultural studies, women's studies, history and sociology. Within the label 'discourse analysis' there are a large variety of approaches, many of which are philosophically and/or methodologically incommensurable (Wetherell 2001a). The following authors give a more detailed history of ideas and approaches which have influenced discourse research: (Ainsworth-Vaughn 2001; Cameron 2001; Jaworski & Coupland 1999; Potter & Wetherell 1987; Wetherell et al. 2001). Despite this variety in focus and philosophy, discourse methodologies have in common an interest in social interaction, and focus on the constructive nature of language and the social actions of language as key to understanding social phenomena.

Discourse approaches vary along several different axes (although research often does not fit neatly into these typologies) (see figure 2): the first is the level and focus of interest, for example conversation analysts concentrate at a micro level on face-to-face talk in interaction (Maynard & Heritage 2005; Sacks et al. 1974); interactional sociolinguists and ethnographers-of-speaking focus on groups (speech communities) (Gumperz 2001); discursive psychologists focus on the relationship between mind, self and society (Potter & Wetherell 1987); critical discourse analysts and Foucauldian analysts analyse power relationships and institutional practices at the macro level of a whole society (Foucault 1973). The second axis is political: social research can be seen as an apolitical task of describing phenomena, or alternatively can be seen as inherently political in nature and critical in purpose (Dyson & Brown 2006; Fairclough 1989). The third dimension is a philosophical dimension: discourse approaches can vary from positivist objectivist endeavours to find a tangible social reality, to post-

modern subjectivist views that social reality is relative and objectively unknowable (Guba & Lincoln 1994; Woods 1999).

Discourse approaches can employ quantitative methodology, but more commonly embrace qualitative methodology as more resonant with a focus on language use and interpreting phenomena in social context. The diagram below locates discourse analytic approaches along two of these axes: 1) level and focus of interest (micro - macro) and 2) political (description - critique). These approaches may be underpinned by any philosophical paradigm.

Figure 2. Approaches in discourse analysis[8]



An example of work situated in quadrant 'A' is the early conversation analytic study of Sacks and colleagues which showed how turn-taking is skilfully co-ordinated in face-to-face talk (Sacks et al. 1974). In quadrant 'B' is work which explores the way that power is played out in talk between individuals or groups, for example Mishler's study of doctor-patient consultation which used transcripts of talk to describe the way that the doctor's 'voice of medicine' conflicts with and tends to dominate the patient's 'voice of

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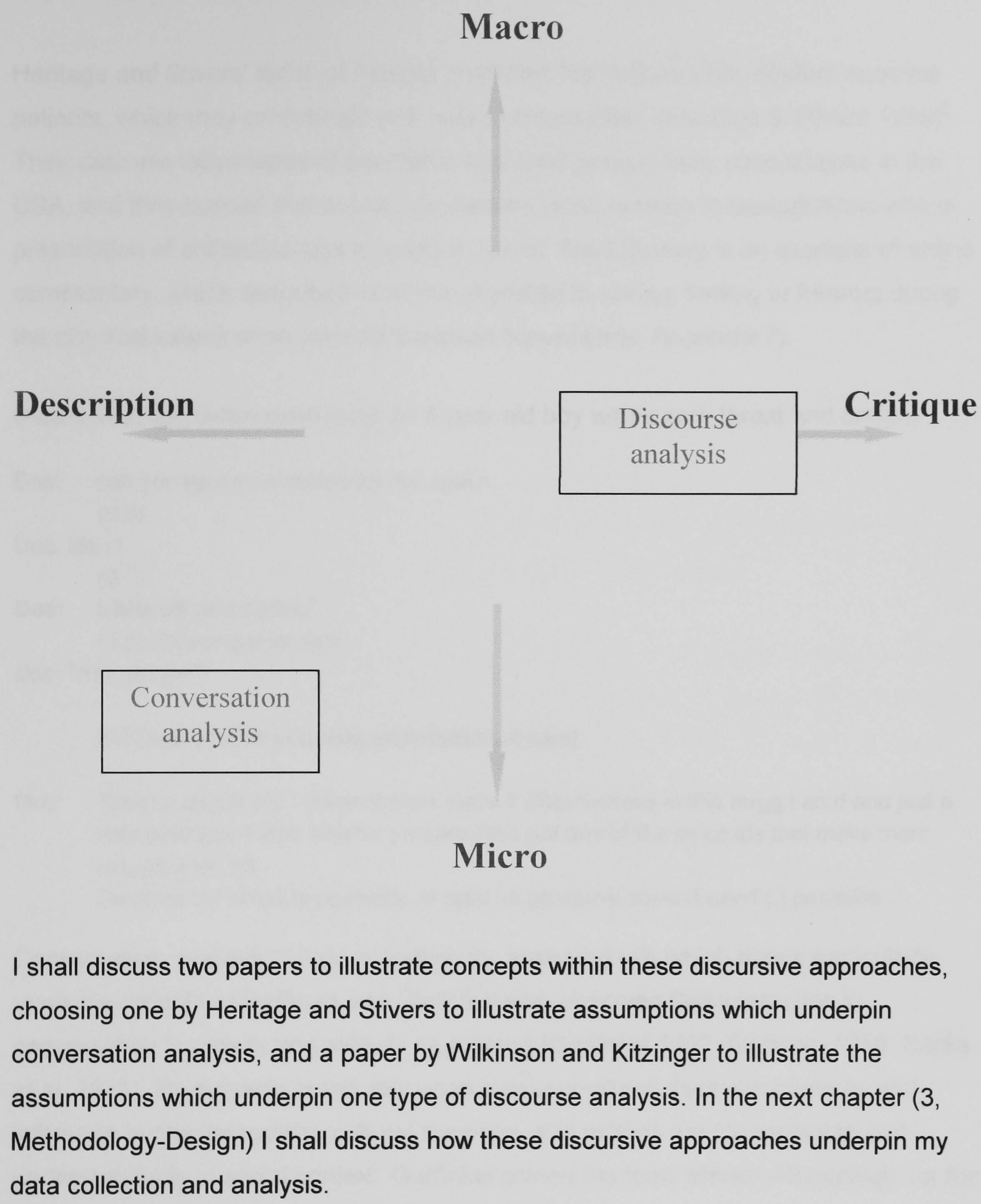
[8] (Adapted from Phillips & Hardy 2002)

the life-world' (Mishler 1984b). In quadrant 'C' is work which uses bodies of texts to trace the emergence of discursive ideas at particular points in history. This kind of work focuses on discursive processes and conditions and practices which facilitate the emergence of particular discourses, rather than power dynamics, for example Horton-Salway's study which traces the emergence of ME (chronic fatigue syndrome) as an illness entity (Horton-Salway 2001). In quadrant 'D', critical discourse analysis is concerned with social practices at a macro level, looking for evidence in bodies of material of the ways in which power is exercised through discursive ideas and practices. For example Waitzkin's work points to the ways that talk between doctors and patients fulfils ideological functions in wider society by encouraging people to see their problems as located within themselves rather than emanating from social injustice (Waitzkin 1989).

In this thesis I draw upon two main discourse approaches: firstly conversation analysis (CA) to analyse coughing at a micro level in doctor-patient talk (in chapter 5). This analysis is mainly descriptive rather than critical. I consider how coughing has significance at a turn-by-turn level and how this is linked with the different phases and tasks in consultation. Going beyond 'pure CA' (Heritage & Maynard 2006) I then explore the ways that coughing is linked with 'being a patient' in consultation. Secondly, in a discourse analysis (DA) I draw upon a broader range of analytic tools (including conversation analysis, sociolinguistic analysis of institutional talk and discursive psychology) to explore doctor and patient identity (in chapter 6). In this analysis I look at the persuasive and evaluative dimensions of talk, linking face-to-face talk (at a micro level) with wider social discourses such as 'patient demand' or 'minor illness' (at a macro level). This analysis is descriptive, but also critical in terms of considering how identity relates to the exercise of power between doctor and patient. I adopt a constructionist philosophical approach to these analyses, explained in this chapter and chapter 3. Figure 3 locates the thesis conceptually:

Figure 3. Conceptual location of this thesis



I shall discuss two papers to illustrate concepts within these discursive approaches, choosing one by Heritage and Stivers to illustrate assumptions which underpin conversation analysis, and a paper by Wilkinson and Kitzinger to illustrate the assumptions which underpin one type of discourse analysis. In the next chapter (3, Methodology-Design) I shall discuss how these discursive approaches underpin my data collection and analysis.

A conversation analysis of doctor-patient interaction

Heritage and Stivers' focus of interest is the talk that occurs while doctors examine patients, which they confusingly call 'online commentary' (Heritage & Stivers 1999)[9]. Their data are video-tapes of paediatric and adult primary care consultations in the USA, and they noticed that online commentary was common in consultations where prescription of antibiotics was a possible option. The following is an example of online commentary, which describes what the physician is seeing, feeling or hearing during the physical examination (see transcription conventions, Appendix 7).

(Acute visit, physician examining an 8 year old boy with a sore throat and cough)

Doc: can you op'n your mouth for me agai:n
(0.3)
Doc: ats i:t
(0.7)
Doc: Little bit re:d (.) hm°
(1.6) ((moving sounds))
Doc: °Alri::ght (h)°°

[42 lines omitted including examination of ears]

Doc: They're alright (h). I mean there's just a li:(tt)le redness in this thro<u>a</u>:t an:d and just a little pinkness ther:e which (.) means he's got one of tho:se co:lds that make them cou:gh a lot .hh
Because his chest is pe:rfectly all right he <u>ce</u>:rtainly doesn't need (.) peni<u>c</u>illin

Conversation analysis (CA) is a method for analysing talk which draws particularly upon the insights of Goffman and Garfinkel who observed that interaction in conversation is orderly and skilfully negotiated (Garfinkel 1967; Goffman 1959; Sacks et al. 1974). Participants in talk rely upon presuppositions, tacit assumptions and inference to give interaction cultural meaning, and actions are recognisable and understandable in social context. Garfinkel coined the term 'ethnomethodology' for the shared methods of practical reasoning people use to analyse, understand and act (Garfinkel 1967). It is the methodical way in which talk is produced which makes it comprehensible to participants. Common-sense knowledge is patchy and revisable, linking in with the idea that meaning is negotiated in interaction rather than fixed beforehand.

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[9] http://www.mpi.nl/world/persons/private/tansti/online_during_acute.pdf

CA asserts that the sequential order and position of utterances is vital in understanding talk. The *way* in which something is said (e.g. tone of voice, emphasis, timing) shapes understanding of what is meant, and the method of transcribing in CA reflects this, indicating the positioning of utterances and prosody such as pauses, in-breaths, emphasis, elongation etc (Roberts 2000c).

In their study, Heritage and Stivers found many examples of online commentary in their large data set of over 300 consultations and outlined several characteristic features: online commentary occurs simultaneously with physical examination, is used to report on signs which are absent or mild, and doctors' statements are in the form of reports ('little bit red') or assessments ('this one looks perfect'). Patients generally do not respond to online commentary: they may be physically unable to respond during examination (e.g. with mouth open etc) but in addition the patient may not be able to see or hear what the doctor can, and/or interpretation of the physical examination findings may require medical expertise (Heritage & Stivers 1999).

Online commentary may serve to reassure patients that their illness is not serious. Heritage and Stivers suggest that it serves another function: to justify and forecast the doctor's upcoming diagnostic evaluation. In the example above, the finding of *some* abnormality (a red throat) serves to validate the mother's decision to bring the child to the doctor, but at the same time this finding is minimised ('just a little redness') and used to support a diagnosis which does not warrant antibiotics (a cold that doesn't need penicillin). Conveying a 'no problem' diagnosis may be difficult because it potentially threatens the patient's 'face' (Goffman 1955) by implying that there is actually nothing wrong and that there was therefore no need to have come to the doctor. A 'no problem' diagnosis also implies that antibiotics are not needed, and this may be unwelcome if patients were hoping for antibiotics. Hinting at a 'no problem' diagnosis with online commentary may make later acceptance of the diagnosis more likely (Mangione-Smith et al. 2003). Drawing on physical evidence also positions the doctor's evaluation as a scientific one, rather than a personal opinion which may be more open to challenge. Patients generally do not contradict the evidence that physicians describe (Perakyla 1998) so this is a powerful way of asserting a diagnosis and treatment.

Conversation analysis gives an insight into the way that talk is patterned and orderly, and transactions sophisticated and subtle. For example, patients do not have to explicitly ask for antibiotics to be understood as requesting them (Stivers 2002a). The design of talk asserts the doctor's authority whilst avoiding overt conflict (but also

swaying the balance away from 'shared decision-making') (Gwyn & Elwyn 1999). Talk can also be seen as actively constructing phenomena: in the example above, the doctor constructs the illness as a cold which is common (one of those colds) and unthreatening (only causing a little redness or pinkness) and therefore not an illness which warrants antibiotics.

Research Aims

CA tends to take an empiricist line, preferring 'unmotivated looking' for phenomena within data (ten Have 1999) rather than abstract theorising (Wetherell 2001a). 'Looking' can never be free of assumptions or theories, or things would make no sense at all (Garfinkel 1967); however, CA is careful to remain 'close to the data', avoiding making analytic claims about phenomena which do not manifest explicitly in talk (for example macro level phenomena such as social class) (ten Have 1999).

What counts as relevant data

The exact sequence, timing and way in which things are said is essential for the interpretation of talk, so recordings of 'naturally occurring' talk are preferred over hypothetical examples or researchers' recollections (ten Have 1999). Since talk in interaction is the focus of interest, CA uses recordings of doctor-patient talk rather than interview data.

Nature of data

Transcription in CA aims to capture as much detail as possible about 'naturally occurring' interaction. Most CA studies focus on verbal interaction, but some include analysis of body conduct (Heath 1986) and/or tools and technologies such as computer use (Greatbatch et al. 1995).

How data can be analysed

CA focuses on fairly short sequences of utterances, drawing conclusions from the structure of sequential turns. For example, "*ooh it's cold in here*" could be a statement or an indirect request to shut the window; the next utterance will reveal how this has been understood (Austin 1962). Replying with "*yes it is*" indicates that the utterance has been understood as a statement; on the other hand, saying "*oh I'll close the window*" indicates that it has been understood as a request. "I'm cold" does not itself have an enduring meaning, but its interpretation depends upon the context in which it

appears. In this way, meaning is context-dependent rather than universal (Garfinkel 1967); in CA, the context includes what has gone before and after, and the way that something is said in terms of emphasis, pauses etc, and this is captured through detailed transcription (Jefferson 1985; Roberts 2000a). CA analyses each sequence in detail, and then compares many examples of particular phenomena to establish normative patterns in talk (Maynard & Heritage 2005).

Position of the researcher

The researcher as a person does not appear in the Heritage and Stivers paper, nor details about the circumstances in which the data were collected or by whom. Analysis in CA remains close to the data rather than being more abstract, and analysts check their interpretations by virtue of the fact that participants signal their understandings of utterances in their responses (ten Have 2002). This approach to data analysis positions the researcher as a rigorous (objective) observer of phenomena, so the researchers' social position (e.g. relationships with respondents, socio-demographic attributes) is not seen as relevant. Heritage and Stivers use active tenses in their paper (e.g. '*we observe*'; '*we suggest that*') which positions them as observers and interpreters of data.

How findings can be applied

Data sets in CA tend to be large, with claims for generalisability being based on describing patterns which are common across many cases (Heritage & Maynard 2006). CA tends to frame its findings within a minimum of wider context (in the example above, details are given only about institutional roles, age of the patient and key symptoms). However, avoiding consideration of wider cultural contexts conveys a somewhat universal applicability for findings which may not be valid (Roberts et al. 2004). CA focuses on individual interactions and tends to be descriptive rather than critical (ten Have 1999) although more recent studies in 'applied' CA (in institutional settings) tend to be positioned more critically in terms of analysing asymmetry in power, and including consideration of wider ethnographic contexts (Heritage & Maynard 2006; Mitcheson & Cowley 2003).

How research can be critiqued

CA can be thought of as empirical micro-sociology (Heritage 2001). Its approach has elements in common with positivist science in that studies often draw upon large data sets and empirical data is presented so that others can verify analytic claims (Wetherell 2001a). The detail involved in transcribing (e.g. timing pauses in exact tenths of a

second) conveys a sense that transcribing and analysis is an exact science rather than an interpretive act (ten Have 1999) (see chapter 3 for discussion of transcribing).

The assumptions which underpin CA are very important for the development of discursive approaches: in other words that ordinary talk is orderly and co-ordinated, that social reality is actively negotiated in turn-by-turn talk, and that talk also achieves social actions (e.g. in this example, preparing to announce a diagnosis and treatment which may be unwelcome). I draw on CA for my analysis of doctor-patient interaction in chapters 5 and 6, and discuss the assumptions and application of CA in more detail there.

I shall now look at a paper by Wilkinson and Kitzinger to illustrate the assumptions which underpin discourse analysis.

A discourse analysis of focus group data

Wilkinson and Kitzinger critique social science research which focuses on 'thinking positive' for people diagnosed with breast cancer (Wilkinson & Kitzinger 2000)[10]. In traditional psychological literature 'thinking positive' is conceptualised as an internalised attitude, evidence of a 'fighting spirit' which researchers correlate statistically with cancer morbidity and mortality rates. Wilkinson and Kitzinger draw upon data from audio-taped and transcribed focus group discussions and individual interviews with women with breast cancer in the UK in which women spontaneously talked about the importance of thinking positive. For example:

Jessie: So, I just broke down and cried (pause) when it just struck me, when I was out the place, I was out on me own, I didn't want to (pause) do it in front of people (Karen: yeah) didn't want to embarrass myself (pause), but erm (pause) no, I was erm (pause) I was upset but I accepted it (pause) and thought well I've got rid of it now.

Karen: yeah, oh aye you do, don't you

Jessie: yeah you've got to. (Karen: yeah) you've got to think positive haven't you?

(Wilkinson & Kitzinger 2000 p802)

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10 http://www.lboro.ac.uk/departments/ss/depstaff/staff/publications/wilkinson_pdfs/Kitz&Wilk.thinkpos.pdf

Wilkinson and Kitzinger analyse the context in which thinking positive is invoked in women's discussions. 'Thinking positive' is an idiom which reflects culturally patterned, morally acceptable ways of reacting to cancer (Sontag 1991). Idioms are widely shared generalities upon which co-conversationalists can concur. In this example, reference to thinking positive comes at the end of Jessie's quite detailed description of her reactions to a cancer diagnosis and she uses it in a vague way. Wilkinson and Kitzinger argue that position of the expression functions as a way of wrapping up what has just been said and moving the conversation on to less painful or difficult topics. It also creates the opportunity for someone else to speak, and reinforces conversationalists' sense of belonging to social and cultural groups. The focus group participants were also constructing identities through their talk: thinking positive is a culturally accepted, morally sanctioned way of responding to illness and in describing themselves as thinking positive, this conveys that women are not responsible for their illness. These discursive functions of idioms can be seen as social actions: dealing with sensitive topics (Silverman 2001b), negotiating opportunities to speak (Goffman 1981), affiliating to a group (Gumperz 1982b) and building a social identity as a breast cancer survivor (de Fina et al. 2006).

This article critiques dominant social science research in profound ways. A literal interpretation of women's talk about breast cancer supports the notion that women commonly draw on thinking positive as a coping strategy. However, analysing the talk in context shows that talk about thinking positive has interactional functions. A discursive approach to analysing talk moves the analytic interest away from internal emotional states and towards an understanding of talk as it is actually used in social situations (Jaworski & Coupland 1999). This approach does not deny the existence of individual thoughts, but focuses on how thoughts or feelings appear in talk, and how they function interactionally, rather than trying to define the nature of individuals' cognitions (Potter 2001).

Research aims

Talk itself has become the focus for Wilkinson and Kitzinger, illuminating interactions between focus group participants, instead of using talk as unproblematic access to internal cognitive structures (thoughts, feelings, attitudes, beliefs etc) (Potter 2001). The research explores the meaning of the term 'thinking positive', taking this in the context in which it appears, and its meaning in specific interactions, instead of trying to establish decontextualised, fixed meanings for the concept of 'thinking positive'.

Nature of data

In this study focus group data is seen as the product of social relationships: relationships between researcher and participants, and relationships between participants. The analysis focuses on interactions between focus group participants rather than between researcher and participants. It is implied that knowledge about the respondents' positions (their gender, age, class, and recent breast cancer diagnosis) is directly relevant for interpreting what was talked about and how. The content of focus group discussion is linked to wider social discourse (e.g. seeing 'thinking positive' as a culturally shared idiom). 'Meaning' is therefore understood as culturally shared rather than individually defined (Maybin 2001).

What counts as relevant data

Relevant data in discourse research can be any text including documents, interview data, recordings of talk, or data such as images (Gwyn 2003b).

How data can be analysed

Discourse analysis draws on CA in being concerned with the context in which things appear, language in use and social relationships, and in deriving conclusions from the data rather than abstract theorising (Alvesson & Karreman 2000). However, DA extends analysis beyond individual interactions to macro-social phenomena such as race or gender (Hall 2001; Hollway 2001). Wilkinson and Kitzinger do not say exactly how they analysed the data, but they give extracts of data with discussion of their interpretation of these examples.

Position of researcher

The Wilkinson and Kitzinger paper is written in an active voice (e.g. *'we use our own data to explore how women with breast cancer talk about thinking positive'*) and their findings are presented as interpretations which challenge others' conclusions about coping with cancer. In a separate paper, Wilkinson and Kitzinger discuss the relationship of the researcher to focus group participants, and position her as actively shaping the research rather than being a separate, neutral observer (Wilkinson & Kitzinger 2003) .

How research can be critiqued

Wilkinson and Kitzinger's analysis is rigorous in that all instances of 'thinking positive' in their data were analysed. They do not do checks of validity or reliability, but present examples of data for the reader to assess. Their findings are positioned as interpretations which resonate both with their data and with a wider social reality, and not just as arbitrary re-interpretation of traditional research findings. They have moved analytic interest away from internal cognitions (the focus of traditional research on thinking positive) and towards processes in social interaction, seeing social reality as culturally and historically relative and as actively renewed in interaction (Burr 2004). I discuss these ideas further later in this chapter.

What conclusions can be drawn

Wilkinson and Kitzinger's findings challenge traditional approaches to attitude research and they also discuss political dimensions of their findings: cancer morbidity and mortality are associated both in medical and popular literature with failure to think positive and women's cancer coping strategies are therefore open to moral evaluation (Sontag 1991). Their findings challenge strategies designed to help women think positive (e.g. counselling) and also challenge the socio-cultural context in which cancer patients can be held responsible for the outcome of their disease (Wilkinson & Kitzinger 2000).

In summary, discursive approaches therefore lead to a serious critique of social research which treats language as an unproblematic reflection of social reality, proposing instead a research approach which takes into account the constructive nature of language, the social action which is accomplished through discourse, and the interpretive nature of any human endeavour including research. I draw on DA to analyse doctor and patient identity in chapter 6, and discuss in more detail assumptions and applications of DA in that chapter.

Seeing talk as discourse has far-reaching implications for assumptions about the nature of research data: what does this mean for how the URTI literature can be understood?

Epistemological status of the URTI literature

In chapter 1 (review of URTI literature), I treated the findings of quantitative attitude surveys with scepticism, but gave more credence to findings from ethnographies and qualitative interview studies. I have been careful to specify the settings and methodologies which have led to the study findings (e.g. '*In an ethnography of common infections including fevers, chills and colds in suburban Londoners in the 1980s..*') positioning study findings as historically and culturally specific and as products of research rather than as enduring truths.

I have drawn upon study findings to illustrate theoretical principles rather than as evidence of 'how things are'. For example, Cornwell found that people in her study in London's East End in the 1980s said that approach to life should be cheerful and stoical, and that being fit for work was important (Cornwell 1984a). I have not understood this as evidence that East Enders *were* cheerful and stoical, but that these qualities were seen as culturally desirable, and that discourses about health and illness were linked with discourses about work in this population. These ideas are theoretically applicable to other settings (e.g. that there are socially sanctioned responses to illness which are likely to be linked to behaviour such as time off work).

I have treated the findings from studies of doctor and patient perspectives on URTI as exemplars to illustrate that the meaning of illness is socially defined (e.g. labelling and responding to symptoms as 'normal' or 'illness') and that response to illness is inseparable from social contexts (e.g. disruption to normal roles, attitude to work). This literature also indicates that illness invokes moral evaluation, for example judgements about the legitimacy of taking time off normal duties and/or seeking health-care.

I have therefore treated the URTI research findings as historically and culturally specific, and as products of particular research methodologies rather than as straightforward representations of social reality. In specifying who found what, when and how, I have also positioned researchers' findings as contestable. The themes I have presented reflect discourses particular to 21st century primary care (such as lay/professional misunderstanding, notions of appropriate consulting, GP burnout) and also reflect inequalities in control over research (for example most research is conducted by medical professionals or academics and not patients) (Turner & Beresford 2005). These epistemological considerations also apply to my own research:

I discuss my position as a researcher, the nature of consultation and interview data and the nature of 'research findings' in the next chapter, Methodology-Design.

I now wish to pick up on two concepts which underpin discursive approaches to data, and my analyses: the social construction of phenomena, and understanding talk to be social action.

Social construction of phenomena

A traditional view of language sees talk as simply describing pre-existing phenomena (Kress 2001). For example, in this data from the 'online commentary' paper discussed earlier, the doctor seems to be describing objective physical findings:

Doc: They're alright (h). I mean there's just a li:(tt)le redness in this throa:t an:d and just a little pinkness ther:e which (.) means he's got one of tho:se co:lds that make them cou:gh a lot .hh
Because his chest is pe:rfectly all right he ce:rtainly doesn't need (.) penicillin

From a discursive perspective, rather than being simple description and naming, the doctor's talk can be seen as actively constructing this patient's illness as a 'cold', with connotations that colds are common ('one of those colds') and not serious (i.e. only causing a little redness or pinkness). This construction of colds in general (and this cold in particular) as 'minor' helps to reinforce the doctor's assertion that antibiotics are not necessary.

The literature review in chapter 1 reflects a 'weak' social constructionist view that URTI illness does not have universal meaning but that concepts are socially and culturally variable (e.g. varying with age, gender and social grouping). In a discursive constructionist model of social interaction, 'meaning' is conceptualised as fluid, dynamic, and continually re-negotiated in talk (Weick 1995). People draw upon background expectations, models and ideas (Edwards 1991) and these meanings are then modified during the course of interactions (Garfinkel 1967; Mishler 1984a). For example, doctors are more likely to prescribe antibiotics when a candidate diagnosis of 'Strep throat' is proposed by patients (Stivers 2002b) and doctors also seem more likely to label an infection as bacterial if they think that patients expect antibiotics (Coenen et al. 2000).

Although meanings can be understood to be co-constructed and negotiated, doctor-patient power relationships are asymmetrical and biomedical meanings predominate

(Fisher & Dundas Todd 1986; Gwyn 2003d; Gwyn & Elwyn 1999; Waitzkin 1989). For example, doctors dominate the structure of medical interactions (Marshall 1988) and biomedical conceptions of disease are privileged over 'life-world' concerns in consultation (Mishler 1984a).

Medical science frames its language as scientific and neutral, claiming to be value-free and objective (Gordon 1988). Deconstructing this conception of medical language (and of medicine itself) shows that medicine is underpinned by ideological values (Fleischman 2001). For example, visible (and preferably measurable) illness is given more credence than other criteria such as feeling unwell (Gordon 1988). Taking the example of doctors' language in case presentation, the epistemological status of patients' accounts is undermined with language which frames their opinions as subjective and unreliable (e.g. 'the patient *reports* pain' or '*denies* a history of cancer') in comparison to doctors' opinions which are framed as objective ('she has a blood pressure of 120/80') (Fleischman 2001).

The analysis of metaphor gives an interesting insight into the ways that phenomena are socially constructed (Cameron 2003), showing that medical language is heavily metaphorical rather than literal (Gwyn 2003c). Medical endeavour is characterised by over-arching metaphors such as 'medicine is war' and 'the body is a machine' (Fleischman 2001; Kirmayer 1988; Mabeck & Olesen 1997). Fighting metaphors were common in my data set; in the following example both doctor and patient draw on fighting metaphors to describe how illness struck.[11]

Consultation Dr 8 and Pt T, lines 99-103:

Pt T: yes and sometimes just cough uncontrollably (..) yes

Dr 8: you're getting **attacks of coughing** you can't-

Pt T: yes in the night (..) yes

The same patient's description of a recurrence of her symptoms was accompanied by vigorous gestures with her arms (line 43):

Pt T: yes I think everything just (..) (hands in air) started **exploding** again (.) you know ?

[11] See transcription conventions, Appendix 7

Doctors also used fighting metaphors in connection with treatment:

Consultation Dr 9 and Pt Z, line 244

Dr 9: yes (..) well I think we'll give you a stronger (..) **pain-killer**

Consultation Dr 5 and Pt F line 103

Dr 5: yes no you see you've got lumps there and on this side (..) now these are the lumps that come up (..) are your glands (.) or your lymph nodes .hhh that come up and they're the **body's own defence mechanisms** (..) against infection (..) are you smoking ?

Consultation Dr 11 and Pt S, line 275

Dr 11: so I suspect (..) that (..) your body's going to be able to **fight it off** naturally

One patient suggested the following treatment:

Consultation Dr 8 and Pt T, lines 395-403

Pt T: get garlic

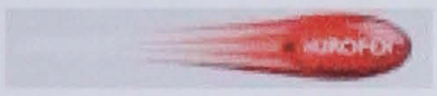
Dr 8: yes

Pt T: ginger (..) and boil it up (..) and squeeze lemon in it and sweeten it with honey

Dr 8: wow

Pt T: and then I take Night Nurse and the next day **it knocks it out**

Advertisements for medicines reflect these fighting metaphors, portraying medicines as the armaments in the battle ground of the body (Fleischman 2001). The following advertisement from the nurofen.com website uses bullet imagery to advertise Nurofen pain-killers (Anon 2006):



Nurofen Liquid Capsules

Nurofen has taken advantage of the latest in technology to bring you Nurofen Liquid Capsules. Encapsulated in the easy-to-swallow capsules is a liquid form of ibuprofen, which is quickly absorbed to provide fast and effective relief at the site of pain.

Target Pain Fast with new Nurofen Liquid Capsules.

Analysis of metaphor illustrates the interlinked nature of ideas in language (Maybin 2001). For example metaphor structures how we think about illness (Sontag 1991) but illness also structures how we think about other phenomena, for example, 'lame

excuse', 'deaf to entreaties', 'arterial roads', 'epidemic of crime', 'cancer in society' (Fleischman 2001).

Metaphors contribute to constructing illness and also set up ways of responding to it. For example, a war metaphor may be helpful whilst there is hope of a cure for cancer, but becomes destructive once the war is 'lost' and someone is terminally ill (Saillant 1990; Sontag 1991). Qualitative interviews with cancer sufferers suggest that 'fighting' may preclude expressing emotional distress (Byrne et al. 2002). Different metaphors can suggest alternative responses to illness, for example life-is-a-journey comparison may be a gentler metaphor to apply to the cancer experience (Reisfield & Wilson 2004): the road may not be as long as one hoped, and important destinations may be bypassed, but there's no winning, losing or failing. Travel metaphors appeared in my data:

Consultation Dr 8 with Pt T, lines 281-7

Dr 8: I think your home remedies are ideal

Pt T: yes

Dr 8: yes (.) you **carry on** doing what you've been doing

Pt T: alright

Consultation Dr 3 and Pt A, lines 13-15

Pt A: and (...) I always think of myself as quite (..) a healthy kind of [guy=

Dr 3: [mm

Pt A: =I do a lot of sport and exercise [ ] I never get ill

Dr 3: [mm]

Pt A: and em (...) just I I usually **ride out** (..) things like f- flu's and colds=

Dr 3: yup

Pt A: =and stuff (..) and but (..) this is kind of different cos (..) it's (.) lasted a long time

In these two examples, 'travelling' types of response to illness were used in the context of self-care (carrying on using home remedies, riding it out with no treatment at all) and are implicitly contrasted with resorting to medication and/or doctors (metaphorically fighting disease with medicines).

Upper respiratory illness lies on the boundary of 'normal' experience (see chapter 1) and this suggests that 'no problem' diagnoses are likely to be common (Mangione-Smith et al. 2003). The agreed nature of an illness (i.e. its construction in consultation) is therefore consequential, both in terms of practical outcomes (e.g. antibiotic prescription) but also in terms of 'face' (Goffman 1955) since a no problem diagnosis may threaten claims to patient-hood by carrying the implication that patients should not have consulted (Heritage & Robinson 2006).

Talk as social action: face work

As I have mentioned, a central idea in discourse analysis is that language is not a neutral vehicle for conveying information, but that it is also a site for social action. There are several social actions explored in the two discursive papers discussed in this chapter. In Heritage and Stivers' CA paper, the doctor's talk contributes to the construction of the illness and also has a persuasive function, laying the ground for the doctor's 'no problem' diagnosis. In the Wilkinson and Kitzinger study, social actions include negotiating opportunities to speak (Sacks et al. 1974), affiliating to a group (Gumperz 1982b) and building a social identity as a breast cancer survivor (de Fina et al. 2006). In describing themselves as thinking positive (which is morally sanctioned) women were also conveying that they are not responsible for their illness. This is an example of 'face work', or positive social value that people claim for themselves (Goffman 1967). Goffman suggests that people are constantly involved in mutual evaluations of situations and each other, and are concerned to avoid losing face or threatening others' face. Emotional responses are invoked by particular images of self, with feelings of pleasure if events establish a face that is better than expected, and hurt if expectations of face are not fulfilled (Goffman 1967).

The moral, evaluative dimension of interaction (evidenced in face work) is particularly salient for URTI consultations. The literature review in chapter 1 indicated that consultation for 'minor' illness seems to be morally questionable since URTI lies on the boundary of normality and socially sanctioned 'illness'. Doctors' categorisation of patients and/or their illnesses carry negative associations which reflect moral evaluations (e.g. 'rubbish', 'dross', 'dregs'). 'Minor' respiratory illness also invoked affective associations for doctors, for example feeling frustrated or burnt out by trivial consultations (see chapter 1).These evaluations were not automatic or inevitable, however. The literature suggests that doctors' definitions of 'inappropriateness' were variable, depending upon day-by-day changes in work situation as well as judgements

about the character of individual patients and the nature of the illness. Judgement and evaluation is a two way process, and there is evidence that patients judge the competence and legitimacy of doctors, for example expressing more confidence in doctors who are formally dressed (McKinstry & Wang 1991). Apparently minor transgressions from expected behaviour can cast doubt upon legitimacy, for example keeping equipment in a plastic bag instead of a doctor's bag (Gwyn 2003a).

Evaluation is mutual between doctor and patient. However, the asymmetry of power means that doctors' legitimacy is less contestable (Fisher & Dundas Todd 1986; Perakyla 1998) whereas it seems that patients have to work to 'earn' patient-hood. For example, patients' accounts of their symptoms demonstrate that their problem constitutes an appropriate reason for seeking medical attention (Heritage & Robinson 2006), and patients pre-empt possible negative evaluations of themselves by presenting identities as legitimate help-seekers (Roberts et al. 2004).

The example below from my data illustrates one patient's face work. This patient agreed in consultation to make an appointment to discuss giving up smoking, but expressed a different attitude to smoking in a later interview with me (see Transcription conventions, Appendix 7).

Consultation Dr 1 and Pt B, lines 134-6[12]

*134 Dr 1: well what you could do is (dr puts thermometer into pts ear) why don't you make an appointment with our nurse S** and she can go through the whole (thermometer bleep) (...) thing with you and try and help you (..) you know try (Dr sits down) and feel a bit better (....) get (..) get the smoking (slaps thighs) cut down*

136 Pt B: yeah hhhh I will do as it happens

In later interview with me, Pt B said:

Interview with Pt B, lines 301 to 311

301 JB: Good. OK. The doctor was talking a bit about smoking, I just wanted to ask you about that.

303 Pt B: Yes. He said to me see the nurse, and he gave me advice about it, which was nice of him. I mean, alright it isn't a nice thing to do, but I don't drink, so what else am I going to do? I mean the smoking is my pleasure. I know it's wrong, but I've done it since I was 15, I mean, that's 43 years, so if the damage is done, the damage is done - what's the point of me saying right, I'm going to stop now. It'll probably do more damage for me to stop now than to keep on smoking.

305 JB: Do you feel smoking has got anything to do with your symptoms?

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[12] The line numbers are not consecutive since Atlas.ti software allocates a new line number for each carriage return (Atlas.ti software is discussed in chapter 3).

307 Pt B: No. As I said, I've smoked for 43 years, why hasn't it ... or when I've had a cold before, you know, it hasn't stopped it before.

309 JB: Yes. So do you think that was good advice that he gave you?

311 Pt B: Yes, yes it is. He said make an appointment with the nurse and we'll see if we can stop you from smoking, which, as I said, if I wanted to smoke, I wouldn't need advice from the nurse; to me, it's will power, if you want to do it, you do it. It's no good putting these tablets or having these patches on you; it's will power. You know.

Contradictions are useful starting points to analyse what is going on interactionally (Parker 1992). Patient B appears to agree with the doctor's suggestion in consultation that he make an appointment with the nurse to cut down smoking. This assent is consistent with the actions of a 'good patient' in being compliant with medical advice (Fisher & Dundas Todd 1986). However, Pt B adds the codicil 'as it happens' (line 136) which conveys that it was on his agenda anyway and this serves to resist the frame of 'being told what to do'[13]. In contrast to his assent in consultation, in a later interview with me Pt B conveyed that he had no intention of giving up smoking. He was careful to avoid overtly criticising the doctor, for example saying that 'it was nice of him', and evaluating the doctor's advice as good (lines 303, 309-11). This evaluation of the doctor preserves the doctor's face (the doctor's intentions and advice are portrayed as good), and at the same time avoids a potential charge that Pt B might be unreasonably antagonistic towards doctors. Despite the doctor's 'good advice' Pt B asserts an identity as a strong person who does not need advice or treatment from a doctor or nurse. Analysis of face work therefore helps to explain the patient's contradictory statements. Attention to face emerged as an important dimension of talk in URTI consultations and I explore this in chapter 6.

In summary, I suggest that 'face work' will be particularly salient in URTI consultations because consulting with minor illness is morally questionable. I also suggest that a 'no problem' diagnosis (which is likely in URTI consultations) has the potential to present problems for both patient and doctor: patients' face may be threatened by being seen as an illegitimate help-seeker and doctors' face may also be threatened if a no-problem diagnosis is taken to represent work which is unworthy of a doctor's status and training (Erickson 1999). I therefore suggest that establishing identities as 'legitimate patient' and 'legitimate doctor' will be important in the interaction between doctors and patients with 'minor' respiratory symptoms and that this identity work will also be reflected in post-consultation interviews. I have so far drawn on taken-for-granted meanings for the

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[13] The 'frame' is the definition of the speech activity underway (Tannen & Wallat 1987).

categories 'doctor' and 'patient'. Discursive approaches reconceptualise notions of role and identity (Hall et al. 1999) and I shall explore these briefly below.

What is meant by identity?

In chapter 1, I discussed Parsons' notions of patients' 'sick role' and doctors' 'professional medical role', discussing doctors' obligations to act as gatekeeper to the sick role in URTI consultations, determining who is to be given the privileges of the role and who is not (Parsons 1951). This notion of 'role' implies something which is determined by external social structures (i.e. medical institutions) and is static, formal and 'given' (Davies & Harre 2001). Discursive conceptions of social identity contrast with this in being seen as actively created through language and social practices (Hall et al. 1999). In this model, people actively position themselves and others (Antaki & Widdicombe 1998; Davies & Harre 2001). 'Identity', or 'who someone is' can mean several different things (Zimmerman 1998).

Discourse identity

'Discourse identity' orientates participants to the type of activity underway and reflects respective roles in moment-by-moment interaction (Zimmerman 1998). For example, in the data extract above, the doctor is 'advice-giver' and Pt B is 'advice recipient'. Discourse identities are related to wider structures in interaction, for example, doctors ask questions and give advice which controls the topic and direction of talk (Fleischman 2001). In chapter 5, I analyse how coughing helps to define patients' discourse identities, and how this is also related to 'being a patient'.

Doctor and patient situated identity

Identity as a 'doctor' or 'patient' is a 'situated identity', bringing into play pertinent agendas, skills and knowledge (Zimmerman 1998). Identities can be thought of as frameworks within which actions assume particular meanings and interactional consequentiality (Schiffrin 1996).

A consultation as a particular social event and doctor and patient situated identities are actively constituted by the setting, situation and participants themselves (Sarangi & Roberts 1999). For example, the surgery building and layout invites particular behaviour and relationships (Gesler 1999). The surgery is divided into public and private spaces which help to delineate what activities are expected in different areas: for example, it is patients who are given appointment times, asked to wait in a waiting

room, and called in when a doctor is ready. Symbols accompany medical settings, for example doctors' rooms have signs on the door, a desk, medical notes, stethoscope, blood pressure cuff etc: interaction involves these tools and technologies (Greatbatch et al. 1995; Heritage 1998). A stethoscope is particularly symbolic, acting as a metonym for doctors' healing powers (Lachmund 1992).

A meeting in a medical setting is an institutional interaction, and talk between doctors and patients has particular institutional characteristics. For example, relationships are asymmetrical with unequal rights to participate and unequal access to specialised knowledge (ten Have 1989). The institutional setting also sets up expectations for talk, with social norms for expected topics, particular vocabularies and structure of talk, institutional tasks, constraints and goals (Drew & Heritage 1998b; Sarangi & Roberts 1999). Consultation talk is a medical institutional genre (ten Have 1989) and doctors and patients collaborate to produce talk which is patterned in ways which make the interaction mutually comprehensible (Drew & Heritage 1998b). Consultation talk has particular restricted forms (e.g. doctors do most of the questioning) (Drew & Heritage 1998b) and usually follows the format of patients explaining what is wrong, doctors listening and then asking questions, examining, diagnosing and treating patients' problems (ten Have 1995).

The fine detail of doctor-patient interaction is normatively patterned as well. For example, in patients' symptom talk, symptoms are usually 'centre-stage' with other detail such as emotional response to the symptoms, degree of certainty and context for the symptoms constituting background information (Roberts et al. 2005). Contextualisation cues (e.g. emphasis, velocity of talk) indicate how something is to be interpreted (Gumperz 1982a), for example which information is centre-stage. For example, if patients reverse (English) expected norms by talking about emotional dimensions before physical symptoms, this can contribute to constructing patients as 'anxious' (Roberts et al. 2004).

Identity is therefore 'brought along' to an interaction but is also 'brought about' within the interaction through talk and actions (Auer & Di Luzio 1992). In chapters 5 and 6, my analysis will focus on this latter process of identity formation in-situ.

Transportable identity

Patterns of talk reflect macro-social characteristics such as gender, ethnicity or membership of sub-groups (Auer 1998; Gumperz 2001; Hollway 2001). These characteristics represent 'transportable identity' which is usually visible and assignable

on the basis of physical or cultural insignia (Zimmerman 1998). Someone's identity ('who they are' in a particular interaction (Zimmerman 1998)) will vary according to the context and aims of the interaction and identities may change during the course of an interaction (Antaki & Widdicombe 1998).

Participants in interaction may be aware of some types of classification without 'orientating' to them (i.e. making them relevant) (Zimmerman 1998). For example, Mr B's transportable identity could be described as 'white English 58 year old unemployed man with a cough' but these identities were not all salient in consultation or later interview. In the following example, Pt B makes my gender (and his) salient by referring to me as 'darling' in interview. I discuss my social position as a researcher in chapter 3, in other words my transportable and situated identities.

Interview Pt B, lines 211-217

JB Yes. You sound very fed up about it?

Pt B I am, darling, especially with, you know, I said ... I came around here to see you and I said to my missus, "Well while I'm around here, I'll make an appointment to see if I can see the doctor." And when they tell me to come back Monday, there's two people waiting out there ... if it was packed, I'd say "Yes, all right, I'll go and I'll come back Monday." But it isn't packed out there.

JB Yes. I see what you mean.

Pt B Can you see what I'm saying?

Later in the interview, he made his birthplace salient (and by implication white English ethnicity) with comments about immigrants.

Interview Pt B, lines 255-257

JB Yes. And the National Health Service generally, what do you think of the NHS?

P No, no. I don't agree with it. Er. When I was a kid, when I was younger, yes, but now, they aren't putting money into it, that's the way that I look at it. You know, don't get me wrong, they'd rather have these immigrants come over, give them free houses, treatment, everything else, and people who were born in the country can't get it. That's the way that I look at it.

Pt B's white Englishness was not salient in his interaction with the doctor, although his cockney dialect meant that this identity was obvious. More immediately relevant were identities such as 'smoker' (in the previous example) or 'Saturday morning consulter' which were directly addressed in consultation talk.

Consultation Dr 1 and Pt B, lines 46-48

Dr 1: and why have you come as an emergency on a Saturday morning if it's been going on for that long (.)

[what's brought you here [today ?

Pt B: [because (....) [I might wake up one morning and it's good as gold and then yesterday
I woke up (.) arrgh and I felt terrible again (.) and this morning and I thought well I've just got to get it sorted

The meaning of being a Saturday consulter is to some extent defined by wider social discourses (e.g. discourses about the appropriateness of visits to the doctor [see chapters 1 and 4]) but is also defined within the interaction (the doctor's positioning of Saturday consulting as accountable, and the patient's defence of himself).

Whilst many identities may be relevant in medical interaction, I focus my analysis on situated institutional identities, in other words those of doctor and patient. I draw on two levels of conceptions of identity: firstly looking at how coughing shapes discourse identities, and in turn, how this is linked to situated identity as a legitimate patient (chapter 5). In chapter 6 I look at how doctor and patient identities are constructed through the rhetorical, persuasive design of talk and action. I have discussed concepts of social construction, face and identity. I link these ideas together in my data analysis, tracing the way that URTI illness is socially constructed in consultation, and exploring the way that URTI diagnosis is linked with maintenance of face and the construction of doctor and patient identity (chapters 5 and 6).

I have explained in chapters 1 and 2 why and how I came to be interested in discourse analysis of doctor-patient consultations for upper respiratory tract infections. I now turn to the design of the research project in the next chapter, and implications of my methodological realisations for the research design.

Chapter 3 - Methodology: design of the study and rationale

In this chapter I shall describe the study design, discussing the implications of a discursive approach for sampling, data collection and analysis. I shall discuss the way that methodological realisations led to changing research aims and different approaches to data analysis.

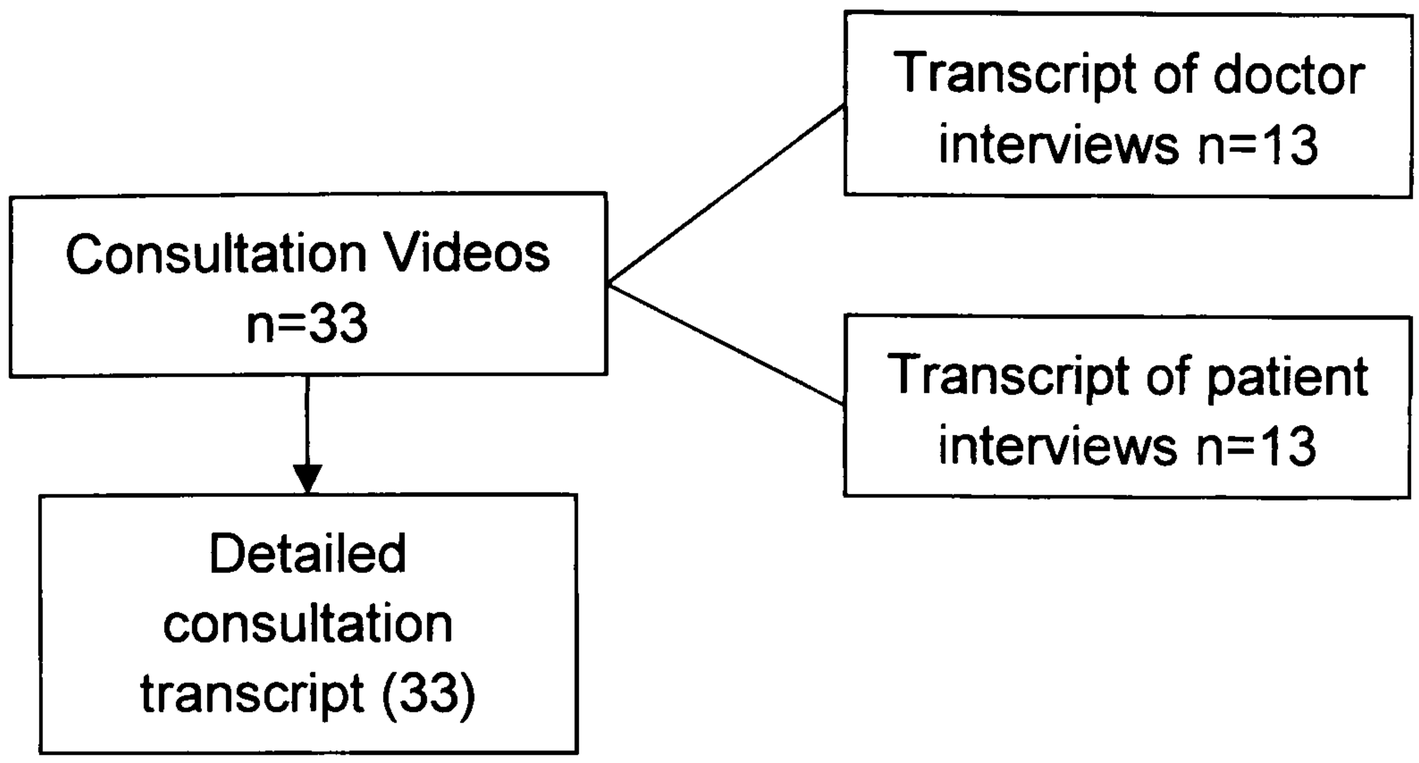
Research Design

Overview of the project design

I recruited sixteen doctors who work in general practices in Hackney, and video recorded consultations with thirty three patients who presented to the doctors with upper respiratory tract infections. I interviewed thirteen of the doctors and thirteen of the patients after their consultations.

I used a semi-structured topic guide and flexible interviewing style to explore potential difficulties in communication, focusing on doctors' and patients' ideas about upper respiratory tract illness, consulting, and roles and expectations of doctor and patient. I played back the video-recorded consultation to participants to explore specific events in the consultation. I audio-taped the interviews and then transcribed the audio-taped interviews and video-taped consultations.

Figure 4. Consultation-related data



I also collected ethnographic information from many sources including policy documents, medical textbooks, patient information leaflets, newspaper articles, clinical guidelines, the proceedings of the General Practitioners' Respiratory Infection Network conference, my own field notes, and notes from informal interviews with practice receptionists and health advocates (discussed later in this chapter).

I analysed data in several different ways: a broad thematic analysis of consultations, interviews and ethnographic data; a conversation analysis of consultation videos; and a discourse analysis of consultations and interviews. These different approaches to the data are reflected in the next chapters. In chapter 4, 'Setting the scene', I present an overview of ethnographic context for the consultations, describing prominent institutional discourses relating to URTI, and topics and activities in consultation. In chapter 5 I present a conversation analysis of patients' coughing, and in chapter 6 I present a discourse analysis of doctor and patient identity. I discuss discursive approaches to data analysis in chapters 2, 3, 5 and 6.

The structure of this chapter suggests a linear progression from project design to data collection, followed by analysis. However the progress of the project was genuinely iterative and the design emergent, with each part of the research process feeding into the design and implementation of other parts (Murphy et al. 1998; Patton 1990). I recruited participants one by one, allowing time to analyse data and to refine the project design and topic guide according to practical and theoretical issues as the project progressed. For example, in interviews I experimented with different ways of asking people about their consultations, comparing using consultation transcripts and playing back the video-taped consultation (discussed later in this chapter). I changed questions on the topic guide if questions did not seem fruitful. More fundamentally, I changed the direction of data analysis as I thought more about the nature of the

interview process and interview data and became interested in discourse approaches, moving away from interest in 'health beliefs' expressed in interview, and towards analysis of the doctor-patient interaction in consultation.

Me as 'research instrument'

'Who I am' (in other words my 'position' in terms of personal and professional characteristics) has shaped all aspects of the project design and conduct, for example the choice of topic, the funding obtained, the collection and interpretation of data, conclusions drawn, and the intended audience for the research (Barry et al. 1999). In a discursive model of social positioning, the 'facts' about my social position are less important than ways in which 'who I am' shapes the gathering, interpretation and presentation of data, so I weave these issues into the description of the design of the research. I write in the first person using active tenses to make explicit my active shaping of the research (Malterud 2001).

Sampling

Maximum variation sampling and theoretical sampling

My aim is to produce a theoretical understanding of issues involved in URTI consultations, so I have used theoretically driven sampling methods rather than seeking a statistically representative sample of patients consulting with symptoms of URTI or the doctors they consult (Arber 1993) (the aims of qualitative research designs were discussed in more detail in chapter 2). Maximum variation sampling seeks a diverse sample by selecting participants who differ according to criteria which are relevant to research questions (Patton 1990). I do not intend to imply that findings can be extrapolated to all doctors, or all patients with URTIs. However, in describing interactions amongst a diverse sample of doctors and patients, the study aims to generate ideas and themes which may be applicable to people in different settings (Pope & Mays 2000). My sampling was also guided by issues which emerged from data analysis ((Miles & Huberman 1994): I selected every instance of patient coughing in consultation (chapter 5), and used theoretical criteria to select one particular doctor-patient consultation as a case study to analyse in detail (Yin 1994). I discuss the 'transferability' of my findings in chapter 7.

I shall outline the ways in which characteristics of individuals and of the setting might impact on consultations for URTIs, and discuss reasons for selecting or rejecting these dimensions as criteria for maximum variety sampling. I used these criteria to select

participants in order to recruit diverse samples of doctors and patients, not to use them as variables in data analysis. As I discuss in this chapter and the previous one, a constructionist approach focuses on 'social position' as it is invoked in interaction, and avoids making assumptions about the significance of demographic variables or other categorisations for participants in interaction. I shall discuss in the next chapter whether participants felt that these criteria *were* salient for URTI consultations, and show in chapter 6 the way that social position is invoked rather than assumed.

Sampling doctors

I obtained a list of general practitioner partners and assistants working in the City and Hackney Primary Care Trust locality. I checked the accuracy of the list and found the names of any regular locum doctors by telephoning each practice. I used this list, together with information provided by Primary Care Trusts and the General Medical Council, to purposively select 16 GPs according to their gender, age and employment status (registrar, assistant, locum or partner) (Patton 1990), ensuring that different practices were represented. I initially wrote to invite participation (see Appendix 1), but no doctors responded. When I followed letters up with a telephone call, all sixteen agreed to participate and to be video-taped. GPs gave written consent for both video-taping and interview (see Appendix 2).

Criteria for maximum variety sampling of doctors

Training and length of time in practice

Training of GPs has varied over time, especially perhaps since the introduction of the MRCGP and vocational training. Training and length of time in practice are likely to influence professional knowledge, attitudes, beliefs and behaviour (Hippisley-Cox et al. 2001). Doctors more recently qualified may be lower prescribers of antibiotics (Whitehouse & Hodgkin 1985). I used GP age as a proxy for length of time in practice.

Employment status

There may be differences in relationships with patients, consulting styles and types of complaint seen by GP partners, assistants, or locums (Evans et al. 2002). I therefore included differences in employment status in the sample of participating doctors.

Gender

Male and female GPs tend to have differing patterns of consultation, for example consultations with female GPs tend to be longer, with more discussion of psycho-social factors (Hall et al. 1994) so I also used GP gender as a criterion.

Practice characteristics

The characteristics of registered patients are different in different geographical locations, and services offered may also affect the practice demographic profile (e.g. the presence of health advocates will attract particular patient groups), and so the type of practice in which doctors work will affect patient sampling for this study (Hippisley-Cox et al. 2001). I selected doctors from different practices (large and small, and in

different locations across the borough of Hackney) in order to increase the likelihood of sampling socio-demographically varied patients.

Sampling surgeries

There are likely to be differences in the characteristics of patients who attend pre-booked or emergency appointments, and who attend in the daytime, evenings or Saturday mornings (Stoddart et al. 2003) so I recruited patients from a variety of surgery sessions.

Time of year

The incidence of respiratory tract infections increases markedly in the winter months in the UK (Fleming et al. 2003). I therefore collected data during the winter, from September to March.

Nurse consultations

There are calls for nurses to take on expanded roles in primary care, particularly in addressing chronic illness, or 'minor illness' such as URTIs (Butler et al. 2001) (see chapter 4). However, nurses' role in primary care is developing and can be difficult to define (Carnwell & Daly 2003) so nurse consultations are not included in this project.

Sampling patients

I recruited patients during surgery sessions held by participating clinicians. I attended surgeries at different times during the week to sample patients attending in different types of appointments (e.g. pre-book-able, drop-in, or Saturday morning emergency). I invited all patients who had appointments with participating doctors to participate in the study by approaching them in the waiting room with a show-card which said '*Are you going to see the doctor with any of these symptoms? Sore throat, running nose, cough, cold or flu?*' (see Appendix 3). Using a show-card instead of asking out loud was intended to preserve confidentiality about patients' reasons for attending the surgery. I sought written consent to participate in the research if patients expressed initial interest in the project (see Appendix 4). I asked consent to video-tape the consultation and to interview afterwards in patients' homes, or in the surgery if preferred. I recruited at least one patient per clinician. Some clinicians saw more patients with URTIs than others because of a combination of doctor characteristics and appointment system (for example, senior doctors tended to have fewer urgent appointment slots).

Defining upper respiratory tract infection

It is difficult to define upper respiratory tract infection precisely, both from the biomedical point of view and from the sufferers' point of view. URTIs may be talked about in medical literature in terms of symptoms (e.g. sore throat), pathological process (pharyngitis) or aetiology (e.g. bacteria/virus). In clinical practice URTIs are not given a precise diagnostic label, but are usually a diagnosis of exclusion, labelled as 'viral illness' once other more serious illness such as pneumonia has been ruled out (Coenen et al. 2000). 'Folk' models of URTIs may be discrepant with a textbook biomedical model, with a large range of beliefs about causes and manifestations of chills, colds and fevers (Helman 1978). The boundary between 'folk' and 'medical' models may be quite blurred in practice, with general practitioners and reception staff drawing upon folk models for diagnosis and treatment, and patients accommodating biomedical explanations for their illness (Helman 1978) (see Literature review, chapter 1). Discrepancies and differences in definitions of URTI illness is one of the topics of interest in this research (analysed in chapter 6), so I deliberately used a loose definition of URTI to recruit subjects:

- Patients who were suffering with one or more symptoms of sore throat or running nose with or without a cough arising within the last two weeks were invited to participate in the study.
- Patients with chronic symptoms (arbitrarily defined as longer than two weeks) and respiratory tract symptoms solely due to non-infective conditions such as asthma were excluded.

Criteria for maximum variation sampling of patients

I used sampling criteria which the literature indicates may have an influence on consulting behaviour and/or expectations in consultation (discussed in chapter 1).

Age

The consultation rate for URTI varies with age, with children under 5 years old being the most frequent attenders (OPCS 1992). Expectations for antibiotic prescription seems to vary with the age of a patient, with adults more likely to want antibiotics for themselves than for their children (Butler 1998b). In addition, beliefs about causes and manifestations of URTIs vary with age (Helman 1978). This study includes patients who are 16 years and over, since qualitative work on consulting with URTIs has tended to focus on children rather than adults (Cornford et al. 1993; Kai 1996b) and adult consultations with URTIs are less well understood.

Gender

Patterns of morbidity vary by gender, with women reporting poorer health and more long standing limiting illness (Scambler 2003a). As discussed in chapter 1, women consult more frequently for all reasons including URTIs, except at the extremes of age (OPCS 1992). In experimental conditions, women were more likely to develop colds after exposure to viruses, but men were more likely to 'over-rate' their symptoms (Macintyre 1993). I therefore included both male and female patients.

Socio-economic status

The study is set in the London borough of Hackney. I chose to set the study in Hackney since it is an area which is diverse in terms of household composition, socio-economic status and ethnicity (Griffiths 1996) (see chapter 4, Setting the Scene). Variations in morbidity are related to income, with poorer people suffering more illness (Locker 2003). The consultation rate varies with socio-economic status and reasons for attendance may be different: for example children in poor areas may be more likely to attend for cold symptoms (Edwards & Pill 1996). General practitioners may respond differently to different patients, for example being more likely to prescribe antibiotics for socio-economically deprived patients (Kumar et al. 2003). I decided to use employment status as an indicator of socio-economic status (Stronks et al. 1997) since asking about income, education or material goods seemed overly intrusive.

Competence in English language

I used two indicators of competence in English language: I excluded patients if they had brought a language interpreter to an appointment, and secondly, if they did not appear to understand my verbal explanation of the project. The decision to exclude those who were less skilled in English language was a dilemma: on the one hand 'cross-cultural' communication is a daily reality in general practice, particularly in inner cities (Roberts et al. 2005); on the other hand, translation introduces an additional layer of complexity to qualitative analysis (Ellen 1984a). I discuss this dilemma in more detail in the Discussion, chapter 7.

There are practical problems in obtaining a sample of patients according to the criteria chosen. Since URTI is an acute problem, most appointments will not be booked very far in advance. Many practices are now offering 'Advanced Access' appointment systems where appointments are made within a couple of days (Murray & Berwick 2003) or patients simply wait to be seen. Selection and invitation of a diverse sample in advance of the appointment would require knowledge of the reason for consulting and information about patient characteristics which is not accessible in advance. I therefore

decided to invite all patients with URTIs to participate in the study and to continue recruiting until the desired diversity was represented in terms of age, gender and employment status (as a proxy for socio-economic status). I describe the research participants in chapter 4.

Data

The data comprised the following pieces of consultation-related data: 39 video-taped consultations, 33 of which I transcribed[14] and 26 transcribed interviews (13 doctor and 13 patient interviews). I also had the text of one e-mail which was one doctor's story about a recent URTI consultation, and ethnographic material including documents, field notes and notes from informal interviews with practice receptionists and health advocates. I also kept a reflexive diary which I used as a tool to enrich data interpretation (I discuss the way I used these materials later in this chapter).

Video-taped consultation data

I regard the video-taped consultation data as the core data for analysis: I have discussed in chapter 2 the reasons for focusing on analysis of actual interactions between doctors and patients rather than other methods such as post-event interviews. I shall describe how I collected the video-taped consultation data and discuss some advantages and limitations of video data.

Video data collection

The camera I used is a small digital video camera with an additional directional microphone (see photograph, Appendix 8). I set this up on a stand in consulting rooms, angled to capture as much of the faces and bodies of both doctor and patient when sitting at the desk in consultation. I turned the camera on before eligible patients entered the consulting room so that doctors did not have to remember to do this, and I left the room during consultations. I turned the camera off after patients had left the consulting room, checked patients' consent for the video recording, and invited patients to participate in a later interview.

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[14] I had access to six video-taped URTI consultations from another project (Moss & Roberts 2005) and used these as additional reference material to explore ideas, but could not include them in analysis since consent had not been given for this particular analysis.

Advantages of video-recorded data

I chose to video-tape consultations because a) it is 'naturally-occurring' data and b) video-tape provides a visual as well as an auditory record.

Naturally occurring data

Recordings of 'naturally occurring' events have advantages over hypothetically generated examples or recollection because interaction is complex (ten Have 1999). Communication in a consultation is naturally occurring in that it is institutional talk between doctor and patient which was scheduled to occur independently of the presence of the researcher and is therefore less subject to influence of the researcher's agenda than data generated specifically for research (Heath 1998). However, no data generated for a research project with subjects who knowingly participate in research can remain uninfluenced by the research process (Silverman 2001a): for example, knowing which patients have volunteered to participate in the research allows doctors in this study to presume that their problems include upper respiratory symptoms, and this may alter the focus of a consultation away from other concerns.

The presence of the video camera was referred to in several consultations. In the following extract, the patient's child comments on it:

Consultation Pt EE and Dr 8, lines 380 -392

Child 1: [MUMMY WHY ARE YOU GETTING FILMED

Dr 8: [yes?

Pt EE: because em .. 't.. °something° (??)

Dr 8: someone's doing some research find out about doctors and patients

Pt EE: research yes

Child 1: too a big tummy there . and a big tummy there everywhere a big tummy

Dr 8: because your mummy's famous that's why she's getting filmed

Both doctors and patients may be conscious of being recorded, and alter their behaviour to present themselves in a positive light (Goffman 1959). Patients who agree to participate in research or teaching involving video-taping do not seem to mind the presence of a video camera (Cromarty 1996; Martin & Martin 1984) but it is not known

how a video camera may affect the consultation from a patient's point of view (Arborelius et al. 1992). Studies of doctors' behaviour show that the presence of a video camera does not seem to affect quantitative measures such as consultation length, the number of problems dealt with, and time in consultation spent on activities such as questioning, giving information or social discussion (Pringle & Stewart-Evans 1990). The doctor in the data extract above joked in interview about the influence of the camera:

Dr 8 interview, lines 146-152

JB Does this consultation feel like a fairly typical one for you? I mean, were you quite aware of the camera and ...?

Dr 8 No, of course not. I would have had her out of the door in a minute if it hadn't been for the camera!

JB *(laughs)* Would you really, yes?

Dr 8 No.

JB No?

Dr 8 No. That was terribly tongue in cheek! *(laughs)* No, *(mumbles)* ... which I would tend to at least have a bit of a go at usually, so it wasn't ...it wasn't way out of the ordinary. *(little laugh)* But what I consistently do is try to end the consultation at that time ...

JB Well it took quite a long time, the whole thing, didn't it?

It is inevitable that the process of recording affects the resulting talk, However, the consultation talk can still be seen as naturally occurring in terms of the institutional relationships of participants, and institutional aims and constraints (Drew & Heritage 1998b).

Visual record

Most research on doctor-patient communication has concentrated on the spoken word, commonly analysing transcripts of consultations and/or research interviews (Hyden & Mishler 1999). However, the physical environment is also involved in interactions, and communication involves an interplay between words, gestures, body movements, tools and technologies (Erickson & Schultz 1982; Greatbatch et al. 1995; Heath 1998). A medical encounter is an unusual social interaction in that it usually involves physical contact through some form of physical examination (Heritage & Stivers 1999), so the use of a visual record seems especially appropriate for medical settings. I had intended to explore patients' understandings of doctors' physical examinations; however, my research interests changed (discussed later in this chapter) and in fact about half of the physical examinations for URTI took place off-screen.

A video record allows complex events to be subject to detailed and repeated scrutiny (Heath 1998). And unlike interviews or direct observation, exploration of events is not limited by researchers' or research subjects' ability to recollect (Heath 1998). Talk is hugely complex, and unfolds at speed without participants necessarily being consciously aware of the way that they are skilfully co-ordinating with each other and making their interaction meaningful (Sacks 1992). The fine details of interaction such as pauses, overlaps etc may be interactionally very significant, but are unlikely to be remembered by participants. Transcription of video recordings allows the rapid visual and auditory events to be slowed down and represented synchronously on paper, to analyse verbal exchange and its co-ordination with body movements, facial expressions, gaze, equipment such as computers, pens, blood pressure cuff etc (Heath 1986). I discuss transcription and data analysis in later sections of this chapter.

Limitations of video-recorded data

Even with its magnificent level of detail, a video record remains a partial record of events in interaction. Most consulting rooms are fairly small, and only a proportion of the consulting space can be captured with one video camera. Multiple cameras could be used for a more extensive record, but this would present difficulties with the volume of data to analyse (Ratcliff 1995). Angling the camera towards the doctor's desk means that some interaction may not be captured if it occurs in another part of the room. This does, however, allow privacy away from the camera lens whilst still recording verbal interaction. A limited camera angle may exclude participants if the consultation involves more people than simply the doctor and one patient, and this happened with some of the consultations in this study (see chapter 4). The record is partial in that the researcher dictates the start and end points of data collection.

There are resource implications in choosing to use video data: the equipment itself is bulky and expensive in comparison with an audio tape-recorder, transcription is potentially very time-consuming, and high specification computers and reasonable computer literacy are needed to process digital data. It would be impossible to analyse all the audible and visual information available from video recorded talk since there is too much detail available. I have chosen to transcribe words, non-lexical paralinguistic features such as coughing, laughing and sniffing, and some features of body conduct. I discuss transcribing decisions and data analysis in later sections of this chapter.

Doctor and patient interview data

I shall describe the way I collected interview data, and then discuss how I used interview data in the light of the methodological debates in chapter 2.

Collecting interview data

I invited all of the video-taped doctors to participate in interviews: three doctors felt too busy, so I interviewed 13 of the16 doctors. Ten of the interviews took place at doctors' surgery premises, two in their own homes, and one in a university office. Eight interviews were within a week of the consultations; the other five took place up to two months later due to difficulty in arranging convenient times for interview (see diagram 2). Most of the doctors were interviewed during working hours, when they were sometimes interrupted by telephone calls and pressed for time. As a former GP in East London, I had met eight of the 16 doctors before, and know three of the eight reasonably well. I found that it was better to interview doctors before patients so that I did not have access to more information about a patient than the doctors had at the time of consultation.

I invited all patients who had been video-taped to participate in subsequent interviews. Participation in post-consultation patient interviews was poor: I interviewed 13 of the 33 (40%) about their illness and visit to the doctor. Of the 20 other people invited for interview, 4 cancelled interview appointments, 3 felt too ill to be interviewed, and the remainder said that they were too busy or did not give reasons: I shall discuss possible reasons for poor patient participation in interviews in later sections. I offered patients a choice of interview location, since interviews at home may be more comfortable for respondents and facilitate discussion about consultation which may be inhibited in a surgery setting (Stevenson et al. 2000). Nine patients chose to be interviewed at home, and four in rooms within the doctors' surgeries. I interviewed all patients within a fortnight of their consultations, except one who was interviewed three weeks afterwards.

Diagram 2. Participants and timing of post-consultation interviews

Patient participants	Doctor participants	Patient interview timing and location	Doctor interview timing and location *
Patient A	Doctor 3	Same day, surgery	3 weeks, surgery
Patient B	Doctor 1	2 days, surgery	2 weeks, surgery

Patient C	Doctor 4	Same day, home	Same day, surgery
Patient D	Doctor 2	1 week, home	Same day, surgery
Patient E	Doctor 1	2 weeks, home	2 days, surgery
Patient F	Doctor 5	3 weeks, home	Same day, surgery
Patient G	Doctor 6	1 week, surgery	Same day, surgery
Patient H	Doctor 6	1 week, surgery	Same day, surgery
Patient J	Doctor 14	2 weeks, home	Declined
Patient K	Doctor 9	1 week, home	1 week, surgery
Patient L	Doctor 11	2 days, surgery	2 months, office
Patient M	Doctor 7	3 days, home	2 weeks, surgery
Patient N	Doctor 7	Same day, surgery	4 days, surgery
Patient P	Doctor 1	Declined	2 days, surgery
Patient Q	Doctor 3	Declined	3 weeks, surgery
Patient R	Doctor 12	Declined	3 days, home
Patient S	Doctor 11	Declined	2 months, office
Patient T	Doctor 8	Declined	3 weeks, surgery
Patient U	Doctor 13	Declined	2 days, home
Patient V	Doctor 13	Declined	2 days, home
Patient W	Doctor 7	Declined	4 days, surgery
Patient X	Doctor 15	Declined	Declined
Patient Y	Doctor 15	Declined	Declined
Patient Z	Doctor 9	Declined	1 week, surgery
Patient AA	Doctor 9	Declined	1 week, surgery
Patient BB	Doctor 16	Declined	Declined
Patient CC	Doctor 2	Declined	2 days, surgery
Patient DD	Doctor 6	Declined	Same day, surgery
Patient EE	Doctor 8	Declined	3 weeks, surgery
Patient FF	Doctor 7	Declined	2 months, surgery
Patient GG	Doctor 10	Declined	Same day, surgery
Patient HH	Doctor 14	Declined	Declined
Patient JJ	Doctor 14	Declined	Declined

* *Doctors were interviewed about one or more patients at a single interview*

I used topic guides to remind me of domains to cover in interview (see Appendices 5 and 6). The topic guides were different for doctors and patients, since I asked patients about their own experiences of illness and consulting, and asked doctors about the patient/s who had been video-taped and also about experience with patients in general. I watched the video-taped consultations before interviews, and prepared specific questions about events in consultation.

Interviews were semi-structured, meaning that I had a topic guide to prompt questions about particular areas of interest, but that the direction of interviews was kept flexible to allow me to explore respondents' agendas (Holstein & Gubrium 1995). I tried to develop an in-depth interviewing style with open questions, and allowing time and opportunity for respondents to talk in order to be more 'respondent centred' rather than

researcher centred (Britten 1995; McCracken 1988). This was intended to allow respondents to define problems in their own terms, to challenge my preconceptions and to take discussion into areas I had not anticipated at the outset. I followed lines of enquiry which seemed to follow naturally from the topics brought up by interviewees, trying to explore their language and concepts (Britten 1995). For example, in this example, I explore what the patient means by a 'cold in her back'.

Interview Pt D, lines 34-46

Pt D I thought that I'd caught a cold in my back, because I slept with the window open one night, em, but the doctor said that it was just a muscle spasm, she didn't actually say what possibly might have brought it on or whatever. But I do have a back condition, so maybe ... I don't know. It just came.

JB Yes, now that's interesting, what you say about the cold in the back ...

Pt D Yes, that's what I thought.

JB Did you think it kind of started in your back and then developed into a sneezy type thing?

Pt D Yes, because it was just on one side; it still is on one side, it's just that I'm coping with it better, because obviously, I'm on the drugs now, but it's just on one side and um. Obviously I don't know how I've slept, but I just feel that that was the side that was exposed. That's me thinking "Oh, I've got a cold in my back" kind of thing, because it wasn't there the night before, it was sudden.

JB Yes. So in some way the weather ... how ... can you explain a bit more about that?

Pt D Em. I'm cold blooded anyway, I feel the cold quickly and it dictates what happens to me very quickly. I've got bad circulation, so as soon as I feel the cold, I try to sort of warm up then or whatever. But if it hits me where I'm unable to control the situation, I get ill and that is why, initially, I thought "I've left the window open - oh my God! That's probably what it is!" because I was fine the previous day.

Each interview was therefore structured very differently, but I tried to ensure that the domains represented on the topic guide were covered in every interview.

I used play-back of the video recordings in interviews with doctors and patients as a prompt to explore events in the consultation (Cromarty 1996) and facilitate discussion of apparently mundane events which may not otherwise have been recalled (Coleman & Murphy 1999). I felt that it would be more meaningful to base discussion on specific events rather than hypothetical situations (Coleman & Murphy 1999; Ratcliff 1995). I invited interviewees to comment spontaneously on the consultation, and also stopped the video play-back at frequent intervals to ask specific questions. I discuss discursive understandings of 'remembering' later in this chapter. Interviews took half an hour to an hour, and I audio-taped them to provide a record for detailed analysis (Gibbs et al. 2002).

Relationships with respondents

Murphy et al. assert that interviews 'cannot be treated as giving unproblematic access to respondents' perspectives and must always be analysed in relation to the circumstances of their production' (Murphy et al. 1998 p123). Interview data should therefore be understood bearing in mind the context in which accounts were produced, the presuppositions upon which they rely, who produced the account, for whom and why (Hammersley & Atkinson 1993). It is therefore important to know how interviewees interpreted who I am and what type of communicative event they (and I) assumed it to be.

I went through a short written introduction at the beginning of interviews with both doctors and patients in order to try and set an agenda for subsequent discussions. I explained the aims of the research to patients as '*to find out about their experiences of being unwell, and of going to the doctor*', also '*to understand more about how doctors communicate with patients who have symptoms of cold, cough, running nose, sore throat or flu*'. To doctors, I said '*consultations for upper respiratory tract infections (URTIs) are very common in general practice, and can create misunderstanding and dissatisfaction for both patients and doctors. This project aims to explore patients' and doctors' experience and viewpoints*'. The aims of the research were prominent on the consent forms, but I also explained the aims verbally to check consent, address questions about the project, and to be clear about my research agenda (Hoddinott & Pill 1997a).

I tried to establish the interaction in the genre of 'interview' (Briggs 2005) in other words a confidential one-to-one discussion intended to contribute to research knowledge. I introduced myself as a researcher and GP (Hoddinott & Pill 1997b). I explained that I am linked with a university (King's College) and not with GP practices or regulatory bodies. I explained that the interview was not intended to test respondents, that information would not be used to judge either doctors or patients, and that information would remain confidential and anonymous. Despite my attempts to specify the type of communicative event and the focus for discussion at the beginning of interviews, people make sense of interactions as they unfold (Garfinkel 1967; Gumperz 2001) and discussion may have evolved into something rather different from the interview genre I had intended (Briggs 2005).

Doctors mostly responded to me as a colleague, assuming shared knowledge and understandings (Chew-Graham et al. 2002). My aim in interviews was to explore

processes of interaction rather than to evaluate consultation skills or adherence to guidelines for instance. However, interviews with doctors often migrated into a frame of 'peer review' or 'assessment' (Ainsworth-Vaughn 2001), with doctors comparing their practice to accepted 'ideal' standards (Campion et al. 2002).

Interview Dr 6, lines 187-189

(Video plays again of parting dialogue of consultation).

Dr 6 I didn't check her understanding! *(little laugh)* MRCGP hat on[15]. I didn't check her understanding of what had happened and stuff, but I hope she was OK with it.

I tried to encourage doctors (and patients) to avoid a clinical/medical agenda, and instead to talk about conceptions of illness which were not biomedical, or attitudes to practice which were not 'rational' for example. Despite my intention, it became clear that post-consultation interviews with doctors reflected a clinical/medical interpretation of consultation talk and tasks. For example, doctor interviewees and I were engaged with a process of reducing and summarising events in order to agree a medical diagnosis in technical terms:

Interview Dr 2, lines 220-222

JB OK. So in summary what did you feel was wrong with her?

Dr 2: Em. A viral URTI mainly causing her nasal and sinus congestion I think really, and then the resurgence of her lower back pain, which I thought was musculoskeletal. Yep.

It is less clear how patients responded to me in interviews: one or two responded to me as a doctor or nurse, assuming that I had medical knowledge, but most seemed to respond to me as an interviewer or counsellor. This comment came right at the end of one of the patient interviews:

Interview Pt D, lines 455-461

JB OK. That's really, really interesting. Thank you.

Pt D Was it?

JB Yes, thanks very much for your time.

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[15] Assessment of video-taped consultations forms part of the examination for the Membership of the Royal College of General Practitioners (MRCGP). 'Checking the patients understanding' is one criteria for a good consultation style (Campion et al. 2002).

Pt D It's funny because I mean I don't know. I usually talk like this when I've been, em ... oh, what are they called? Psycho-therapist consulted, or whatever. I usually talk like this then, but I'm usually in tears, you know, so for me that's another step forward, because I'm not in tears. It's not, em ... maybe because I didn't go so in-depth and I'm glad still, but my children suffered a lot when I was in and out and that I know still makes me emotional every time I think of them, what they were going through at that time, I think "Oh my God!" You know, how did they get through that! It's made us all stronger as a unit, as a family unit, anyway and it's made them a bit more mature.

It is evident that respondents were seeking 'right' answers to my questions. For example, this doctor's answer was marked by pauses, laughter, false starts and repairs, and he finally asks me whether his answer is adequate:

Interview JG, lines 41-42

JB OK. Do you try to sort of get across particular messages about viruses or treatments, or reconsultations?

Dr 8 *(pause)* Erm. It might have come through in the interview that I would try and encourage self care, so encourage them, to support them in what they've done themselves. And *(pause)* I think the whole thing about viruses and bacteria, it's a bit of a ... viruses often mean ... doctors describe illness as being 'viral' in a dismissive way, but we know there's many viruses that kill people. So, it's ... *(little laugh)*. Erm. Actually what we mean is this is a minor illness for which you don't need any treatment from me. So do I have a general message. I suppose it's to make them aware of what are likely to be the important symptoms. Because how <u>do</u> you know when to go to the doctor? *(pause laughs)* Any prompts on this? Am I getting near?

Seeking the 'right' answers is linked with wishing to maintain a positive face as a good doctor, but also a 'good interviewee' (I discuss face in chapters 2 and 7). Identifying myself as a GP probably facilitated access to doctors and therefore also to patients and may have meant that there was a useful alignment between me and GP respondents (Chew-Graham et al. 2002). My GP identity may also have had disadvantages for this research: social alignment with GP respondents may mean that it was difficult to question accepted norms and as a GP I may have been seen as an authority and potentially sitting in judgement (Chew-Graham et al. 2002; Hoddinott & Pill 1997b). There are very different interactional goals and power relationships in qualitative interviews compared with consultations (Chew-Graham et al. 2002; Hoddinott & Pill 1997b) and I found it hard to avoid 'taking a medical history' in interviews with patients. Interview content may have been more focussed on medical topics in both patient and doctor interviews (Richards & Emslie 2000).

Being a GP researcher led to conflicts in role: for example, I found it uncomfortable being in my researcher role whilst waiting in surgeries to recruit patients. I was acutely aware of the time pressures that practice staff were under, and I offered to make tea

and help receptionists to file notes during times when there were no patients eligible for the study. However, being seen sometimes behind the reception area talking to practice staff may have created the impression (for patient participants) that I was a member of the practice team rather than an independent researcher. A few patients asked my opinion about symptoms or general practice organisation in interviews and this felt an awkward shift from interview mode to advice-giving (Hoddinott & Pill 1997b). I gave some general advice about appointment systems for example but avoided giving medical advice, instead directing people back to their GPs. Some GPs asked my opinion about the evidence for particular cold treatments which positioned me as an 'expert', and reflected a misunderstanding of what the research was about. I was unable to answer this kind of question which felt embarrassing.

I have briefly discussed how my social position as a GP may have been relevant for understanding interview data. Similarly, my gender (female), age (41), class (educated, middle class) and ethnicity (white British) will undoubtedly have impacted upon my relationships with respondents (Cornwell 1984b; Oakley 1993; Richards & Emslie 2000; Silverman 2001a; Song & Parker 1995; Warren 1988). These factors form part of the communicative context of interactions, but may be more or less salient at different times (see chapter 2). Within interactions, the frame (for example therapy talk, interview talk) and footing (e.g. peer-peer, interviewer-interviewee) shapes meaning (Erickson & Schultz 1982; Goffman 1959; Roberts & Sarangi 2005): I analysed interview data with these communicative contexts in mind, taking these into account to help interpret what was said. I will discuss data analysis more fully in later sections of this chapter.

Researching colds as a topic

Patients seemed surprised to be asked to participate in interviews about their cough and cold symptoms and sometimes found it hard to respond to my questions about their illness. Patients seemed to have few narratives to draw upon about their experiences of respiratory illness (Bury 2001) and their opinions about the causes and nature of their illness seemed generally very vague (Kleinman 1980). This is a typical extract from a patient interview:

Interview Mrs E, lines 45-50

JB Mmmn. So, going back to the first time you got the cold, do you have any idea what caused it?

E No, not really. I suppose everybody gets colds.

JB Uh huh. Yes. And you said it was something sort of going round, is that right?

E Yes. That's what my son said, yeah, he said a lot of people have had it, yes.

JB Mmmn. And do you have any idea what might have caused lots of people to have it?

E No, you see if one takes a thing, erm, that's when people going out, they pass it around from one to the other, I suppose. Yes. Mmmn. And if you work with people who have one cold, one person comes in with their cold and everybody gets it, don't they? (??). So, that's how it goes around.

Another patient said:

Interview Pt F, lines 207-217

JB And do you have an idea why you might have got this?

Pt F What?

JB What do you think caused it this time?

Pt F I don't know. No idea, no idea. I just thought it was a bug going round. *(chuckles)*

JB Yes. Do you think you got it from somebody else, or in the air, or the weather?

Pt F In the air, yes.

Illness impacts upon people's sense of self and social identity and forming narratives is an important way in which people make sense of sickness and communicate their experience to others, particularly with threatening and chronic illness (Bury 2001): this is perhaps not true of transient illness like URTI. Perhaps having few stories to recount about experience of coughs, colds and sore throats may have influenced patients' participation in interviews. In contrast, doctors seemed to have plenty of resources to draw upon: recording consultations on video-tape and reflecting on one's own practice is familiar to doctors (Campbell et al. 1995).

Video play-back in interviews

I experienced several practical and theoretical difficulties with playing back the consultation video to interviewees. A video record makes available for scrutiny a usually private and confidential interaction, and the process felt awkward for me, and I think also for respondents. One doctor expressed her reluctance in interview:

Interview Dr 5, lines 167-175

JB Can we have a quick look at the consultation?

Dr 5 Do we have to? *(laughs)*

JB We don't have to, no!

Dr 5 Why do we have to do that?

JB It's to stimulate ideas really. So, if you're reminded, "Oh yes, that one".

Dr 5 Yes, I should look at them anyway. I've got to do them for my MRCGP.

A video record also presents a great deal of auditory and visual information (Heath 1986) and I found that the visual information sometimes detracted attention from focusing on the doctor-patient interaction: for example some respondents made comments about their physical appearance. I therefore tried eliciting feedback in two other ways: firstly by using a written transcript of the verbal exchange, and secondly using play-back of the audio-track alone. Eliciting feedback using a transcript is not feasible unless literacy is good, and it is difficult to know which part of the consultation is being commented on if participants are silently reading the transcript, so I abandoned this in favour of listening to audio-record. I played the audio-track of the consultation by plugging speakers directly into the digital camera. The small screen on the camera itself was occasionally useful as well, for example to see what was happening in silences.

My understanding of processes in interview has changed over the course of the project. At the time I collected the data, I used play-back of video-taped consultations in interviews with both doctors and patients to prompt recall, in other words to find out 'what really happened', and 'what was really meant' in consultation (Arborelius & Timpka 1990; Coleman & Murphy 1999). In a positivist model of social research, I had assumed that reality comprises static facts which simply need to be truthfully recalled to give a picture of past events. A discursive perspective changes the way that social interaction can be understood.

What does a discursive model of interaction mean for interpreting interview data?

In chapter 2 (Methodological Journey) I discussed the way that talk can be understood as achieving social actions, for example the way that talk about 'thinking positive' functions to bind a group together, and may not be meant to be understood literally. Discursive approaches observe that the same event can be recounted in different ways on different occasions to different audiences for different interactional purposes (Davies & Harre 2001; Parker 1992). People's accounts can therefore be seen as particular versions of events which need to be understood in the context of the social interaction in which they were created (Briggs 2005; Buttny 1993; Potter 2001): the content of talk cannot be understood separately to its context and social functions. My analysis treats both the consultation talk and interview talk as accounts, and I explore the way that patients' and doctors' accounts build their identities in chapter 6.

Events are understood and remembered in particular culturally determined ways (Billig 2001) and the way that events are talked about will also depend upon the social interaction between interviewer and interviewee. New meanings will be brought to experiences through talk in interviews and in consultation (Erickson & Schultz 1982) and interviewees' recollections can be seen as retrospectively constructed accounts which help to make sense of experiences rather than a literal recounting of events (Weick 1995). There are likely to be contradictions between doctors' and patients' accounts of their own actions given in interviews, and 'facts' apparent in video recordings. For example patients may talk about themselves in interviews as active despite their observed behaviour being quite passive and compliant in interactions with doctors (Stimson & Webb 1975).

Contradictions are not surprising from a discursive point of view, since what people say and do depends upon their interactional goals, and these vary in different situations (see chapter 2) (Parker 1992; Potter & Wetherell 1987). I found it quite difficult to manage contradictions in interviews, since I also wanted to avoid implying that respondents should justify their behaviour. However, mutual evaluation is inevitable in interaction (see chapter 2) and behaviour is socially 'accountable' (Goffman 1955). I made assurances that I was not intending to judge people's behaviour[16]. Despite this, the process of video play-back sometimes felt interactionally awkward.

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[16] At the beginning of interviews I said something like the following to participants: "*Questions may sometimes seem silly, or answers obvious, but I don't want to assume things which are not right. Whatever your opinions are they will be really useful*". See Appendices 5 and 6.

Constructionist critiques of social research have led me to feel that a researcher cannot be sure about the 'truth' of events described in interview or consultation. Discursive approaches also redefine the nature of social reality as actively created in interaction. This shifts the focus of study from the *content* of talk to the *function* of it, and to events in the interaction itself. I have not therefore treated interview data as literal descriptions of reality, but instead as allowing insights into what is happening in interaction between doctor and patient (see chapters 2, 5 and 6). I have used interview data in several ways:

1) As an ethnographic resource to understand the wider discursive context for URTI consultations, for example institutional, political and policy contexts, and more immediate contexts such as circumstances of consulting and institutional tasks and roles (see below, and chapter 4).

2) To provide insights into how respondents (doctors and patients) talk about events in consultations and use particular terms and concepts. Interviews allowed an analysis of what was happening in consultation from different perspectives, but not with the aim of fixing 'what really happened' or 'what participants really think'.

3) I have also used interview data to supplement my consultation case study, seeing whether themes from the consultation analysis (legitimacy, identity, rhetoric, and face) were reflected also in interviews. I present this analysis in chapter 6.

Ethnographic information

I have worked as a GP for eight years, so I have 'insider' knowledge of general practice as an institutional setting (Ellen 1984b; Sarangi & Roberts 1999). My familiarity with the professional world of general practice gives me an understanding of medical terminology and the organisation of specialised tasks, tools and technologies (Heath 1998; ten Have 1995). As mentioned in the last section, I drew upon patient and doctor interview data as ethnographic, contextual information to understand more about participants' experiences in and out of the consulting room, and to explore their discursive ideas about 'minor illness', 'doctor workload' etc (see chapter 4).

I spent quite long periods of time in surgery waiting rooms and reception areas whilst waiting to recruit eligible patients. I took the opportunity to informally interview receptionists and Turkish health advocates about their experiences and views of

patients who consult with URTIs. I took notes after these informal interviews, and also noted the context in which consultations and interviews took place: for example, time of day, what type of surgery session and appointment, and a sense of the doctors' and patients' experience in surgery sessions (e.g. telephone interruptions, late-running, emergencies). For example, one doctor was doing the drop-in emergency surgery on a Saturday morning when she received a telephone call from a patient who was very distressed. The patients in the surgery waited for quite some time before she was ready to start seeing them, and she said in later interview that she had found the morning quite stressful. This may or may not have affected her interaction with patients; it was not evident in the video-taped consultation data. I have used this kind of data as ethnographic information which forms part of the institutional context in which doctors meet patients (Ainsworth-Vaughn 2001; Fisher & Dundas Todd 1986).

I also collected texts relating to URTI consultation in primary care including Department of Health Policy documents (e.g. Subgroup of Antimicrobial Resistance & DOH 1998), guidelines for URTI management for general practitioners (e.g. SIGN 1999), NHS Direct guidelines (Banks 2000), medical textbooks and the British National Formulary (BMA & RPSGB 2001; Swash 1995), newspaper articles and patient information leaflets. Materials published by the 'Developing Patient Partnership' (a charity partly funded by the Department of Health) claim to produce 'user tested' health information resources but I could not find any material written by patients themselves. Newspaper articles featured scare stories about pandemics of avian flu, but little about URTI. The URTI literature review in chapter 1 and interviews with patients supply ethnographic information which represents patients' points of view. However, medical institutional discourse dominates the ethnographic material that I collected. I identify discourses relating to URTI consultations in chapter 4, and comment on how these ideas create 'subject positions', or locations within discourses (for example 'responsible patient' vs. 'time-waster') (Davies & Harre 2001).

Ethical issues

I checked participants' consent at recruitment, gaining written consent to participate in video-taping and also to participate in interviews (see Appendices 2 and 4). I also checked whether consent was ongoing, asking after consultations and during the course of interviews.

I was careful to safeguard participants' confidentiality, using a show-card to find out whether patients were consulting with coughs and colds (see page 72 and Appendix 3),

and using numbers and letters on transcripts instead of names. I guarded against disclosing participants' opinions to other participants in interviews, in other words doctors' comments about patients and vice versa.

There was one particular ethical dilemma about information disclosed in a patient interview: the patient was a 58 year old who consulted on a Saturday morning with pain on swallowing, a sore throat and cough which had gone on for weeks. He had noticed a lump on his neck which the doctor felt was a lymph node. The doctor diagnosed a virus infection, and questioned the appropriateness both of consulting on a Saturday, and the patient's request for antibiotics. The patient alluded to his worry that his symptoms might be due to cancer in the post-consultation interview. I felt that he might be right and that cancer should be excluded especially in an older man who was an ex-smoker. I did not say this to the patient, but I mentioned my concerns the GP when I was next at the practice. This was awkward since I felt I was potentially going back on my reassurances about not judging participants, but I felt that a duty of care to the patient over-rode my concerns about offending the GP (Hoddinott & Pill 1997b).

Transcription

I transcribed interview and consultation data from audible sounds and visual images into written text in order to be able to study the detail, to code sections, and attach comments. The process of producing a written text which is readable and meaningful involves reduction, interpretation and representation of the original event, and the task is therefore a subjective and social process rather than a straightforward technical task (Green et al. 1997; Mishler 1984b; Roberts 1997). I made different decisions about reducing, interpreting and representing the interview and consultation data (discussed below).

Data reduction

Making a recording involves reducing the original data. Particular respondents and particular periods of time must be selected, and elements such as off-screen visual detail, smell etc are not captured. Speech contains non-lexical verbalisations, false starts, repetitions, interruptions and overlaps (Tilley 2003) which are often omitted in written transcripts. There is a balance to be struck between readability and accuracy of a transcript; for example transcription of encouraging noises in interview or consultation (Mmm, etc) may be kept to a minimum to avoid cluttering the text. The data may be reduced by choosing not to represent time (e.g. length of pauses, precise moments of

overlap in speech) or manner of speaking (prosody such as emphasis, speed, tone of voice etc.) (Green et al. 1997).

Interpretation

Vocalisations may be difficult to understand because of the recording quality (e.g. quiet volume, overlaps in speech, interfering noise), and differing accents or styles of speech. People makes sense of talk by drawing upon knowledge of language structure and meaning (Green et al. 1997). Sounds are interpreted in the immediate context in which they appear (i.e. in relation to what has gone before, and what follows) and also in wider contexts (e.g. understanding a question and response format to be an 'interview' genre of interaction) (Maybin 2001).

There may be particular issues with interpretation and representation where interviewees do not share the same first language and culture as the interviewer or the transcriber (Green et al. 1997). Prosodic features of language contribute to meaning (Roberts 2000c): prosody is patterned differently in different speech communities, and so interpretation needs to take into account differing styles of speech presentation (Roberts et al. 2005).

Data representation

Written language is represented in particular standardised ways which may be quite different from audible speech. For example the verbalisation 'hwaryuhh' is much more easily read and understood if represented as 'How are you?' (Roberts 1997). Punctuation and capital letters may be added to aid readability, and decisions must be made about how to represent grammar (e.g. 'sometime it hurtin'' compared with 'sometimes it hurts') and linguistic variety (e.g throat/troat; isn't it/ain't it/innit). Choosing to use the grammar and spelling conventions of standard UK written English therefore represents respondents in a particular way (Roberts 1997). Decisions about how to present speech on paper may affect the way that the transcript is interpreted, for example labelling speakers as 'patient' and 'doctor' brings into play particular assumptions about the interaction (Taylor 2001). I assigned numbers to the doctors and letters to the patients, omitting detail which could identify GP practices, or individual doctors or patients in order to preserve confidentiality and anonymity (Punch 1994).

Transcribing is an interpretive practice and is therefore the first step in data analysis. The level of detail required for the transcription varies according to the type of

methodology and the aims of data analysis (Green et al. 1997) and I transcribed interview data in a different way from consultation data.

Transcribing interview data

The audio-taped interviews with doctors and patients were prepared for analysis by a professional transcriber who represented spoken words using Standard English grammar and lexicon, adding in punctuation to aid the readability of the transcripts. She made a note of features such as laughter, long pauses or interruptions to the interview, but she omitted encouraging noises which overlapped with talk and social talk which was not about illness or consultation. The transcribing process involved reducing the data in other ways, for example choosing not to represent time (e.g. length of pauses, precise moments of overlap in speech) or prosody (Green et al. 1997). Parts of the audio-tape which were inaudible were marked with ("??"). The following is an extract of an interview transcript:

JB: Yeah, yeah. OK. Do you find URTI consultations straightforward? Are there difficulties or dilemmas do you think for you?

Dr 7: Erm. They ... they ... No, they are fairly straightforward in that, you know, there's a sort of medical side which I think I'll quickly think, this is a bit more serious, you know, and I'll probably do that through a mixture of what I see and just a general assessment, with my eyes, before I've even examined them. And a few ... you know, simple screening questions. And if it ups the ante, then it stops being a simple, you know, URTI type consultation, it becomes something else. You know, if I think they might have a more, you know ... a more serious illness or infection. And it can ... and also, on the sort of communication side, it can be ... it can be difficult, in that you know you've made the decision that they're OK, but some people are very, erm ... you know, they're quite driven by thinking either that they want some medicine, or they want ... they almost want a sort of ... a sort of, erm, a meatier diagnosis.

I listened to each audio-taped interview in order to compare my interpretation of what had been said with that of the professional transcriber. I made some changes to transcripts, mainly where medical terminology was used, or if interviewees spoke with pronounced accents.

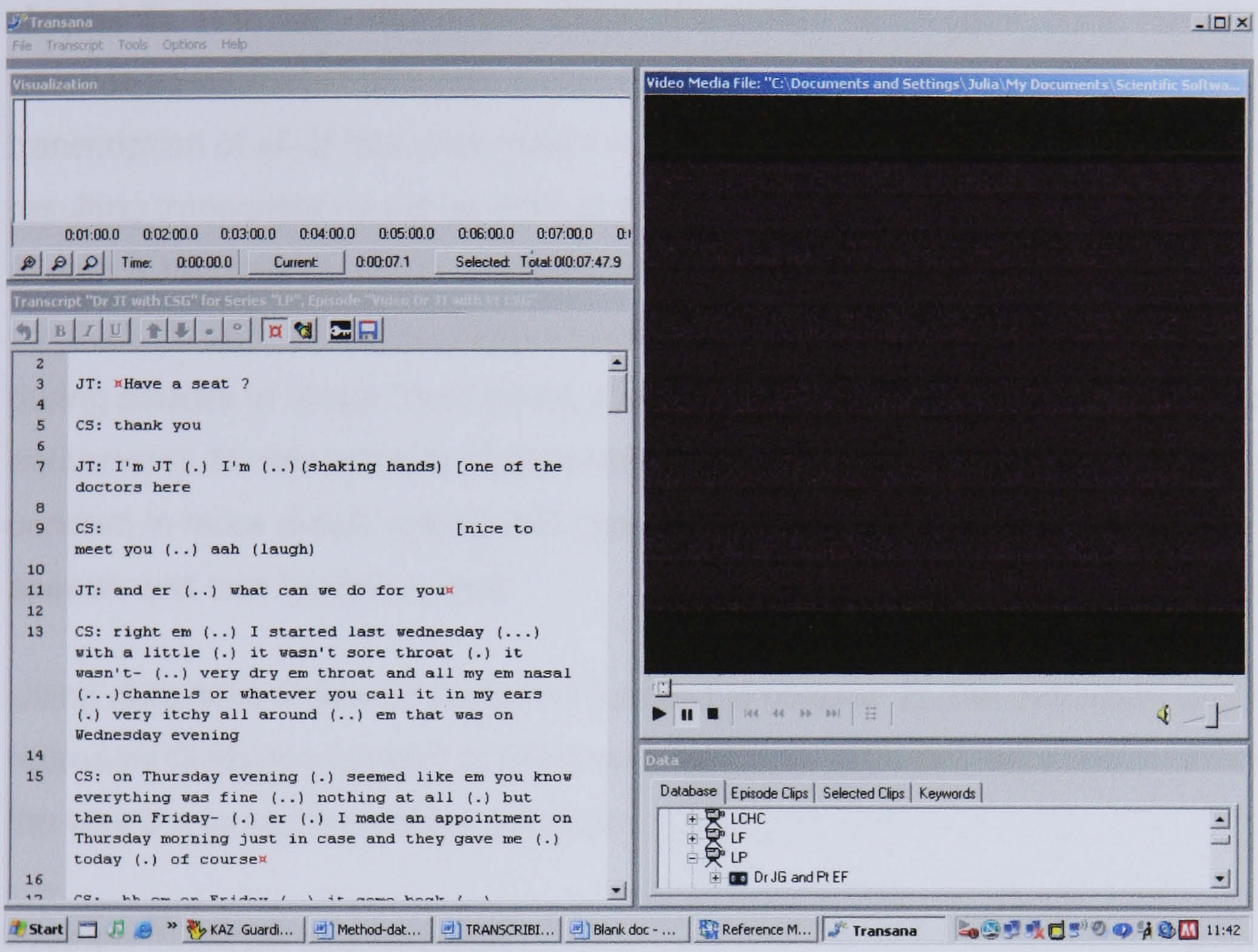
Transcribing video consultation data

Transcription is more challenging with video–recorded data than audio data. There is a potentially overwhelming amount of information in a video record: verbal interaction, non-verbal interaction, and contextual detail such as the layout of the room, and this is

very time-consuming to transcribe and analyse (Coleman & Murphy 1999). In addition there are fewer conventions for the transcription of visual data (Heath & Hindmarsh 2002).

I used Transana transcription software which plays the video whilst allowing simultaneous typing into a word processing window (Fassnacht & Woods 2005):

Figure 5. Transana transcribing software.



I analysed the video data using three analytic approaches: thematically for an overview of events in consultations (chapter 4), a conversation analysis of patients' coughing (chapter 5) and a discourse analysis of identity (chapter 6). I transcribed *how* things were said or done, as well as *what* was said, since the way in which things are said conveys meaning which would be missed in representing words alone (Roberts 2000c).

I represented spoken words using Standard English lexicon since representing sounds more literally is difficult to read (for example 'asitappens' instead of 'as it happens') and invites assumptions about the intelligence or even the character of the speaker (Preston 1985). I presented data in turns, dividing it into semantic chunks if turns were very long (see below). I used punctuation in a different way from conventions in Standard English, for example noting the length of pauses instead of using commas, and using question marks to mean rising intonation rather than to indicate a question (see Appendix 7-transcription conventions). I noted all verbal and non-verbal sounds,

precise moments of overlap in speech and elements of prosody which are common in conversation analytic transcriptions (e.g. emphasis, volume) (Sacks et al. 1974).

I used visual information principally to deepen understanding of the verbal interaction. For example talk was co-ordinated with activities such as using a computer or examination equipment, and so I represented these interactions with tools and technologies in transcripts. I included paralinguistic features such as pauses, breaths, coughs, sniffs and laughs since these can have communicative significance (see chapter 5). The video also yields visual information about gaze, body movement etc, which is co-ordinated with talk and of potential interactional significance, but transcription of all of this information would be a huge task (ten Have 1999a) and resulting transcripts would be difficult to read because of the density of information (Heath & Hindmarsh 2002). I therefore put in two levels of transcription of body conduct: for all talk in consultation I noted body position (standing, sitting) and activities during pauses of longer than about a second (usually typing or using examination equipment); for the extracts of data that I used to analyse coughing I analysed body conduct in more detail, noting also gestures and gaze and their co-ordination with speech and non-lexical sounds.

Using data from Pt B's consultation (quoted in chapter 2), the examples below represent firstly the content of what was said, and secondly the content with features of the way it was said and body conduct:

Example 1: simple transcription

Dr 1: are you a smoker?

Pt B: yes doctor I knew I knew you were going to (??)

Dr 1: (??) how many do you smoke

[……]

Dr 1: well what you could do is why don't you make an appointment with our nurse S and she can go through the whole thing with you and try and help you, you know, try and feel a bit better, get, get the smoking cut down

Pt B: yeah I will do as it happens

Example 2: transcription including some prosody, non-lexical verbalisation and visual detail

Dr 1: are you a sm<u>o</u>ker? (turning to computer

Pt B: yes doctor (looking down) (.) [I knew (..) I knew you were going to (??) (laughing)

Dr 1: *[(??)> how many do you smoke< (smiling)*

[……]

Dr 1: well what you could do is (dr puts thermometer into pts ear) why don't you make an appointment with our nurse S and she can go through the whole (thermometer bleep) (...) thing with you and try and help you (..) you know try (Dr sits down) and feel a bit better (....) get (..) get the smoking (slaps thighs) cut down

Pt B: yeah hhhh I will do as it happens

The greater detail in example 2 takes a very long time to transcribe, but the process of massively slowing down the interaction and careful observation of verbal, paralinguistic features and body conduct allows a much more nuanced interpretation of the data. This level of detail led me to notice the positioning of patients' coughing, and to wonder whether coughing had interactional significance (explored in chapter 5).

Data analysis

I have discussed in chapter 2 and in this chapter a discursive approach to research which positions the researcher as active in shaping the research and data analysis as an interpretive activity. I have also discussed the importance of understanding interaction in its social context, including for example the genre of interaction, the setting and participants, sequences of talk, the immediate context (prior and following utterances), and interaction with the environment and body conduct. Decisions about data analysis therefore reflect discursive methodological commitments. I combined detailed scrutiny of interactional features with a more discursive and ethnographic approach (Briggs 2005; Gumperz 2001; Roberts & Sarangi 2005) placing doctor-patient interaction within an wider institutional and discursive context (see chapters 2, 4, 5 and 6).

Analytic ideas

I drew on others' work to stimulate analytic ideas, reading literature from a range of academic disciplines (Miles & Huberman 1994). There are increasing numbers of conversation analytic and socio-linguistic studies in health settings, but discursive analytic studies are more unusual so I drew on studies on other topics and other

settings, published within disciplines such as socio-linguistics, cultural studies, gender studies, politics and psychology.

Other people have looked at my data and writing (mainly my supervisors, but also other academic colleagues) which has challenged my assumptions or interpretations and enriched analytic ideas. Multiple interpretations of the same data are to be expected in a subjectivist model of social research and I do not therefore see the need for reliability checking which attempts to agree one meaning for data and which effectively closes off analytic avenues (Harper 2003). I present worked examples of data so that readers can judge whether my interpretations resonate with the data, in other words to check the credibility of analytic claims (Morse 1997a).

Reflexivity in data analysis

'Who I am' informs how I make sense of everything, including research data. Handbooks of qualitative method advocate trying to make explicit researchers' assumptions through keeping a reflexive research diary, noting emotional responses, analytic thoughts etc to make tacit, taken-for-granted knowledge explicit (Mauthner & Doucet 2003). Reflexive reflection aims to bring unconscious assumptions into the conscious realm, in other words facilitating researchers to 'know themselves'. Some approaches advocate 'reflexive bracketing' of researcher assumptions, to try and see the data with unbiased eyes (Ahern 1999). Others see reflexivity as a way of making qualitative data analysis more transparent and accountable, allowing readers to see how analytic theories have developed (Morse 1997a; Spencer et al. 2003).

However, there are two main critiques of these models of reflexivity from a discursive point of view: a) that one can never step out from behind the 'cultural lenses' through which we understand phenomena in order to bracket off assumptions and b) that making the unconscious conscious is impossible, since the majority of tacit knowledge remains unconscious and unaccounted for (Cutcliffe 2003). In addition, Cutcliffe points out that time taken accounting for the origin of analytic ideas detracts from actually developing creative lines of thinking. People draw upon pre-existing conceptual frameworks in order to make sense of things (Gumperz 1982a) and I do not believe that one can 'bracket off' these preconceptions. However, I have tried to maintain a self-consciousness about the research process to facilitate thinking creatively ('making the familiar strange') (Agar 1980; Mauthner & Doucet 2003).

I kept a reflexive diary during the early part of the research which helped me cope with the emotional demands of the research process (Barry et al. 1999). I also noted practical and philosophical dilemmas and analytic thoughts. For example, in October 2002, at the beginning of the research, I wrote:

'Set myself quite a task, doing qualitative work [...] feel very ignorant about politics, literature and social science generally. It **is** only the beginning! Anxious about using time well, and learning appropriately. Still in a bit of a paddy about whether my training decisions are right (anthropology modules) [...] don't know what method/tradition to find out about, and concerned that I won't get an overview. Am in a rather dislocated position, doing a PhD in general practice, but learning about anthropology. Don't have a peer group, and the King's award holders are leaving soon'.

A month later, I wrote:

'Beginning to enjoy myself. Realising that knowledge about culture, feminism, queer theory, socialism, all counts and can be drawn upon for my project. Much more enjoyable looking at societies rather than individuals/organs'.

I kept notes about my own experiences and assumptions about URTIs and used these to think about the ways in which my position might affect the ways I gathered and interpreted data, and to question taken-for-granted assumptions (Agar 1980; Barry et al. 1999). For example, I wrote notes about my beliefs about URTIs and their treatment, my own attitudes towards going to a doctor, and my experiences of consulting with patients with URTIs whilst working as a GP in order to have a reflexive awareness of how I might judge respondents and their opinions.

'What are my preconceptions about URTIs ?
(Written prior to data collection)

'Common, not serious, self-limiting, caused by viruses, easy to distinguish from other illness. Manifested through fever, malaise, sore throat, runny nose, swollen glands, cough, sneezing. No need to consult GPs, puzzled as to why people do consult; explained in terms of passport through the door, with intention to present a hidden agenda, expectation of being well and inconvenienced or alarmed by illness, ignorance of natural history, expectation that antibiotics are needed, requiring reassurance from GP that it is not more serious.

Consultations marked by my puzzlement as to why patient has consulted, and what they expect, since this does not seem obvious. Simple advice for management of URTI seems insufficient, since surely everyone knows this ? Patients do not always try any self-management (including paracetamol). Discussion often directed towards avoidance of antibiotic prescription.

Consultations sometimes satisfying if patient obviously reassured (in a short amount of time), but more usually disquieting because of worry about missing a more serious diagnosis, or misunderstanding the patient's 'real' agenda. Concerns about medicalising a common occurrence by taking it too seriously in some way. Difficulties in suggesting self-care without implied criticism of the decision to consult'.

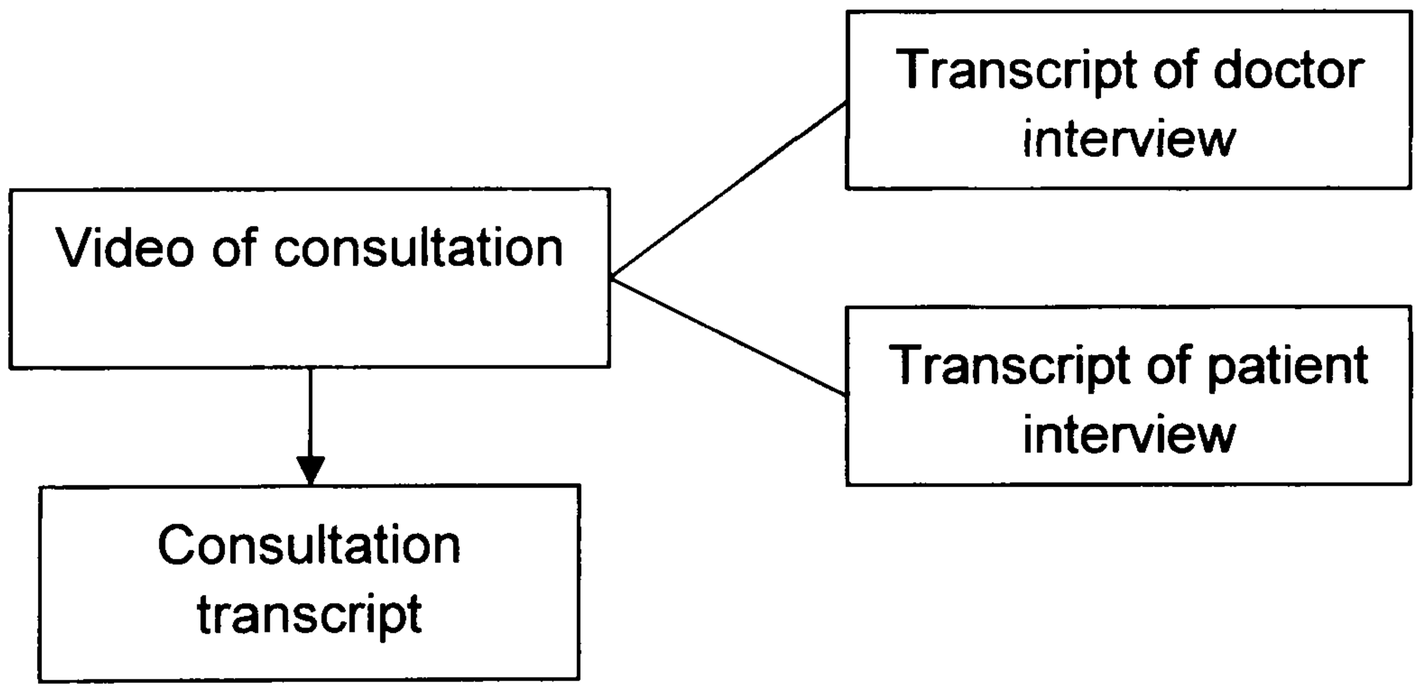
However, instead of extensive abstract reflexive cataloguing of my assumptions, I devoted time to careful thinking about data, trying to see different ways of understanding it.

Data organisation

Decisions made about how to store the data involve categorisation and labelling, and are therefore the first steps in data interpretation and analysis. For example, I labelled the interviews as 'doctor interviews' and 'patient interviews', which emphasises institutional identities rather than gender, age, topic of talk, date of interview, or any other categorisations.

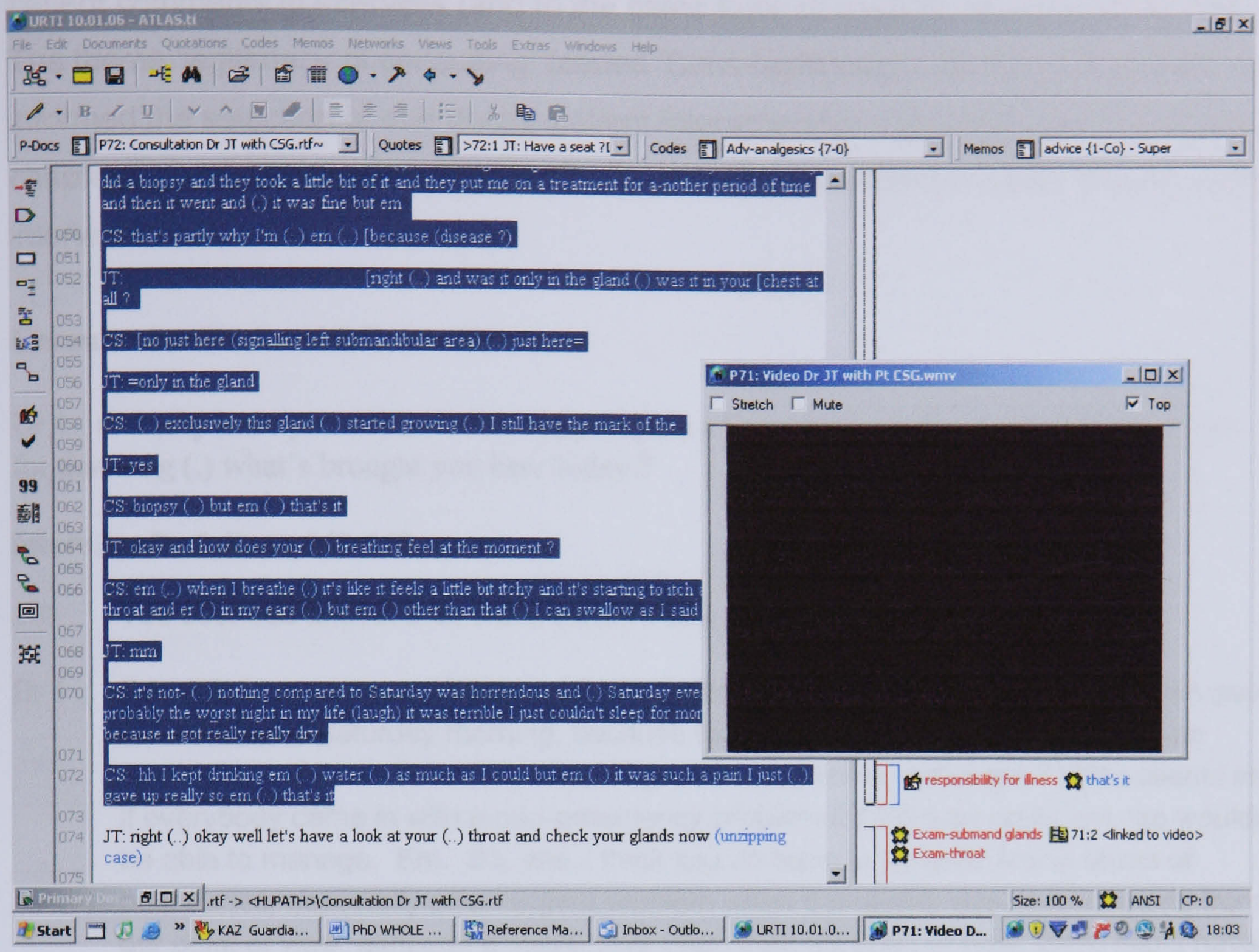
I loaded interview transcripts, consultation transcripts and digital consultation videos onto Atlas.ti software (Version 5.0) (Muhr 2004) and linked sets of data (e.g. consultations with associated doctor and patient interviews; patients as a group; doctors as a group etc).

Figure 6. Consultation-related data



Atlas.ti software for qualitative data analysis allows data to be kept in analytic units (e.g. whole consultations) whilst also allowing non-hierarchical labelling and linkage (Muhr 2004). For example, video clips can be played whilst displaying transcripts, which helps to link written data with visual and auditory information.

Figure 7. Atlas.ti software, transcript and video linkage



I made summaries of each data set (each video-taped consultation with linked doctor and patient interviews) in order to retain an overview of the ways in which the consultation and subsequent interviews were linked. I used Atlas.ti to label different phases in consultations (e.g. symptom talk, examination phase, advice-giving) and topics of discussion in interviews and consultations. My coding reflected topic guide questions and also 'emergent' themes which I felt were of relevance to communication between doctor and patient (Miles & Huberman 1994). For example, I used the following codes to label talk which was about consulting ('cons'):

Cons-access to appointments
Cons-behaviour
Cons-decision to consult
Cons-discussion with others
Cons-emergency
Cons-entitlement to health care
Cons-frequency of attendance
Cons-legitimacy
Cons-reconsultation
Cons-Saturday morning
Cons-shopping around
Cons-sorts of patients who attend
Cons-view of NHS

I used codes to mark relevant data extracts and to link consultation talk to doctor and patient comments in interview (and to the same topic or analytic theme in other data). The theme 'legitimacy of consulting' (coded 'Cons-legitimacy') appeared important, and informed the selection of one doctor-patient interaction for a detailed case study (see chapter 6). In the example below, the code links the consultation extract with the doctor interview.

Consultation Dr 1 and LC, line 46

Dr 1: and why have you come as an emergency on a Saturday morning if it's been going on for that long (.) what's brought you here today ?

Interview Dr 1, lines 143-145

JB: You sounded almost a bit cross there I think. Would that be true, or ...?

Dr 1 Em. Well, yes, I mean I think ... I think patients don't realise the pressure that we can be under on a Saturday morning, because there's only one doctor and if it isn't an emergency problem, then it is frustrating when, you know, we've got 7,000 patients and if everybody came in with a non-emergency problem (which they could do), we wouldn't be able to manage. Em. So, yes, I think you do have to be quite firm in terms of boundaries, especially as an urgent problem when it probably wasn't that urgent, from our point of view, although it might have been from his point of view; there might have been a mismatch in how we were both perceiving the urgency of the situation, probably.

I used analytic coding to become familiar with the data and retrieve particular sections rather than to segment data or place it into hierarchies (Gibbs et al. 2002). I also wrote notes on to paper copies of the transcripts, and used an Excel spread sheet to make notes and allow comparison of particular ideas across the data set. I used the 'memo' function in Atlas.ti to make analytic notes which were linked to particular sections of data. For example, the following memo relates to one of the patient 'cough clips', analysed in chapter 5.

Memo: coughing
Dr involved with computer records. Dr does not alter gaze with the cough. Cough in the context of doubt about the pts account of what happened with his address. Could also be convenient time between utterances to cough. Smoker. Could act to signal readiness to talk when Dr is ready

My analytic questions and foci of interest were different for the conversation analysis and discourse data analysis. However, the practical ways that I processed the consultation and interview data and noted analytic ideas were the same. I shall describe CA and DA approaches to data in more detail in chapters 5 and 6. I made notes on the originals or photocopies of the ethnographic material (policy documents, leaflets, posters, text-books etc) and summarised analytic thoughts on paper rather than within Atlas software.

Whilst I have positioned data analysis as interpretive, I have tried to remain thorough and careful, and to reflect the data honestly (Mays & Pope 2000). For example, I sought 'deviant' cases in order to test the robustness of analytic ideas (Strauss & Corbin 1998). My analysis derives from the data, although my analytic ideas go beyond what can be found immediately in the data (Cutcliffe 2003).

I shall outline in the next section the way that my understanding of discourse approaches changed the direction of my research.

Changing aims of my research

As I have indicated in this chapter, my understanding of the nature of qualitative enquiry changed over the course of this project. I had originally planned a project designed to explore physical examination in consultation, focusing on the meaning of physical examination to doctors and patients. I had intended to elucidate participants' health beliefs (Lawton 2003) and also to explore the non-verbal dimensions of doctor-patient interaction and symbolic meanings of the examination (Lachmund 1992). I had planned to address patients' 'misunderstandings' about what doctors were saying or doing during physical examination.

As I learnt more about discursive approaches to social interaction, I saw problems with this research aim. Firstly, that 'health beliefs' are not static, cognitive phenomena which can be straightforwardly described by individuals, but instead 'meaning' is shaped in the course of social interaction (see chapters 2,3,5 and 6). 'Social reality' is therefore accessible through analysis of doctor-patient interaction in consultation in preference to researcher-generated interviews. I therefore prioritised analysis of the video-taped consultations as core data, drawing on the interview data to allow insight into the doctor-patient interactions, but not claiming to fix 'what really happened' or 'what participants really think' (discussed in earlier sections of this chapter). Secondly, my original research aim was typically doctor-centred, conceptualising 'misunderstandings' as deficits in patients' medical knowledge, and assuming that more information for patients would be the key to resolving problematic communication (Dixon-Woods 2001).

My shift away from positivist paradigms of research and towards discursive views of interactions meant approaching data with a discursive 'mind-set' rather than with a-priori hypotheses (Morse 1997b). Transcribing and coding data led to my noticing particular phenomena: that patients coughed frequently in consultation in a way that did

not seem to be random (analysed in chapter 5); and that 'legitimacy' appeared an important theme for both patients and doctors in consultations and in interviews (analysed in chapter 6). 'Analytic noticing' rather than pursuing specific research questions felt more creative but was also unsettling (as I discuss in chapter 7).

I have discussed in this chapter the way that discursive understandings changed the way I understood the nature of data, and the nature of interactions between doctors and patients, and myself and interviewees. These realisations therefore changed my analytic focus, for example exploring the social function of what was said rather than coding and categorising the content of talk (see chapters 2, 3, 5 and 6).

The position of the researcher is contested in discourse research: conversation analysis tends to position the researcher as an empirical observer, so the personal characteristics of the researcher or contextual details about the process of gathering data are not seen as relevant (ten Have 1999). In contrast, more subjectivist research traditions (such as the Wilkinson and Kitzinger DA approach I have outlined in chapter 2) position the researcher as much more active in shaping the research, and interpreting rather than simply describing (Harper 2003). I have positioned myself as an 'interpreter' rather than neutral observer (discussed in this chapter). I have been careful to ground my interpretations in the data (Sacks & Jefferson 1992). However, my research findings are also social constructions (Burnard 1995).

Discursive paradigms raise questions about the epistemological status of research data and of research 'findings': for example, if accounts given in interviews and consultations (and in research findings) can be seen as one version of events chosen from many possible versions, how does talk relate to 'reality'? (Burr 2004). Some post-modern, radical constructionist viewpoints assert that there are multiple, potentially contradictory ways of understanding the world. In this case, research findings simply present another viewpoint and cannot provide access to an external social reality (Woods 1999). My philosophical commitment can probably be described as 'weak' social constructionist in that I see social phenomena (including research data and research 'findings') as socially constructed: this research is a product of a historical time (2006), geographical space (inner city London, UK) and my own particular biography, shaped and constrained by 21st century medical and social science academic discourse. I do not, however, see my interpretations as totally epistemologically relative and therefore simply another point of view (Woods 1999), but as interpretations which resonate with the data, and therefore with a wider 'social

reality' (Sayer 2000; Yardley 1997). I discuss the epistemological status of my 'findings' in the Discussion, chapter 7.

Chapters 1, 2 and 3 have represented an intellectual journey from a positivist paradigm to discovery of constructionist philosophical approaches. The focus of interest and methodological approach to URTI consultation research has also moved from a quantitative analysis of population-level data and through quantitative and qualitative analysis of doctor and patient perspectives to discourse analysis of actual interactions (see figure 8).

Figure 8. Methodological journey

Methodology	Focus of interest
Quantitative	Population-level data
Qualitative and quantitative approaches	Doctor and patient perspectives
Discourse analysis	Talk in Interaction

In this chapter I have discussed theoretical and practical issues in the design of the study. I now turn to a description of the study setting and participants, and give an overview of events in the URTI consultations.

Chapter 4 - Setting the scene

In this chapter I shall set the scene by giving an overview of the study setting and participants, to place the research in an ethnographic and discursive context. I shall explore themes within medical texts and participant interviews to illustrate the wider discursive context in which URTI consultations occur in the UK. I shall also set the study in an ethnographic context, describing the local setting, participants and events in consultation.

Setting research in context

I have argued in chapters 2 and 3 that interaction must be understood in context. However, there is debate about what counts as relevant context in qualitative research (Schegloff 1997; Wetherell 2001a). For example, the historical, geographical and institutional setting of the interaction, and the gender and cultural background of participants are contextual factors which are reflected in talk and therefore comprise potentially relevant contextual information (see chapters 2 and 3). However, relevant context for an interaction could also include factors such as the weather, room layout, what was on the news that day and so on (Gesler 1999) and it is difficult to know which of a multitude of contextual factors are relevant for understanding interaction.

There is an argument that an analyst's focus should not go 'beyond the data', considering contextual factors only where participants themselves have made them relevant to an interaction (Schegloff 1997). However, interaction can also be placed in a wider discursive context in terms of ideas and practices in society at particular points in history (Cowley et al. 2004; Foucault 1973). Medical institutions are central in the creation and renewal of medical discourse (and at the same time discourse creates institutions) (Armstrong 2002; Foucault 1973; Mitcheson & Cowley 2003), and my analysis sets interactions between individual doctors and patients in a discursive medical institutional context (see chapters 2, 5 and 6).

I have tried to find middle ground between presenting a large amount of contextual information which could detract from the main analytic points, or too little which might make it hard to interpret findings. I first describe the discursive context in which URTI consultations take place in the UK, presenting themes from medical texts including

policy documents, textbooks, patient leaflets etc and also from doctor and patient interviews (see chapter 3). I also place the study in an ethnographic context in terms of describing the local character of Hackney and the participating GP practices, the participants, and an overview of events in consultation. I indicate how contradictory discourses about URTI consultation present dilemmas for doctors and patients.

Political and policy context

There are two main discourses underpinning policy relating to consultations for URTI in the UK: firstly increasing bacterial resistance to antibiotics, and secondly, general practitioner workload.

Bacterial resistance to antibiotics

Discussion about antibiotic prescribing in primary care is underpinned by concern that bacteria are increasingly developing resistance to antibiotics (Department of Health 2002; Subgroup of Antimicrobial Resistance & DOH 1998). Briefings from the Department of Health (DOH) draw upon evidence from randomised controlled trials which show that antibiotics do not make a significant clinical difference to the course of sore throat (Little et al. 1997b), upper respiratory tract infection (Fahey et al. 1998b) or acute cough (Fahey et al. 1998a). Initiatives to reduce prescribing rates emphasise increasing bacterial resistance and clinical ineffectiveness of antibiotics for URTIs (Butler et al. 1998a). There is also concern that prescribing antibiotics results in 'medicalisation', increasing the likelihood that patients will re-attend for future episodes of URTI and increasing pressure on primary care services (Little et al. 1997a). Both URTI consultation rates and prescribing rates are falling, but it is not clear exactly what factors are responsible for this fall (see chapter 1). The cartoon below raised laughter from doctors attending the General Practice Respiratory Infection Network meeting (GRIN) conference that I attended (see chapter 3) and illustrates medical discourses about consulting, medicalisation and treatment efficacy[17]:

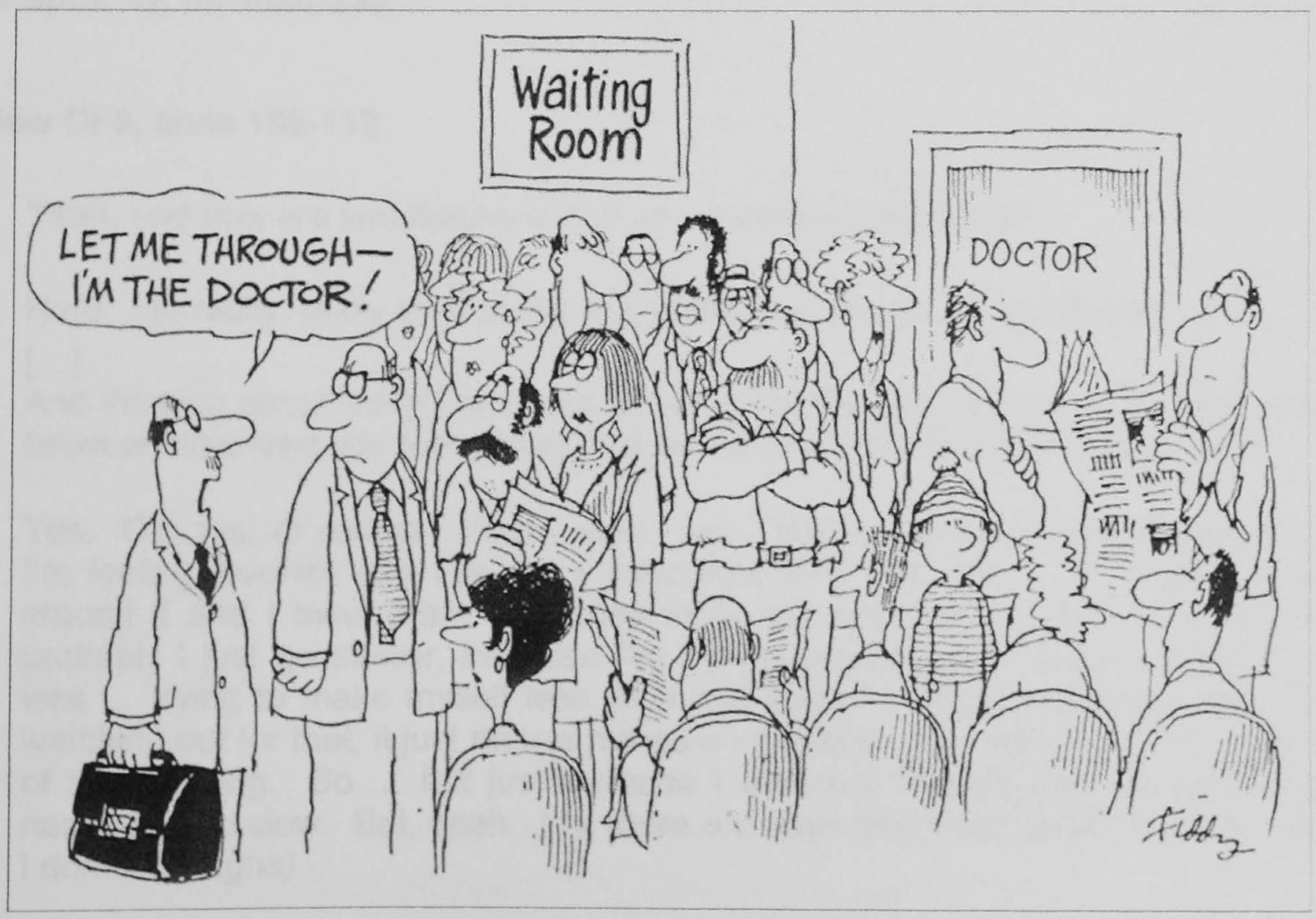
[17] Humour plays on taken-for-granted ideas so can illustrate discourses about 'what everyone knows' (Seymour-Smith et al. 2002). I have included GRIN cartoons where these resonated with the issues that interviewees raised

GRIN Cartoon 1

Workload in general practice

Primary care literature reflects discourses about GP workload (Waller & Hodgkin 2000) with discussion of rising consultation rates (Jenkins-Clarke & Carr-Hill 2001) and increased demand for quicker access to health services (Murray & Berwick 2003). There is also concern about recruitment and retention of doctors, and professional burnout (Evans et al. 2002).

GRIN Cartoon 2



Discourses about 'evidence-based prescribing' (i.e. reducing antibiotic prescribing) and doctor workload were prominent in post-consultation interviews with doctors. Most doctors described URTIs as a regular feature of their work:

Interview Dr 5, lines 3-13

JB Can I ask, how frequently do you feel that patients consult with coughs, colds and sore throats?

Dr 5 A lot more than they should, so quite frequently. I mean I don't know how many. In the winter, I would think I probably see (I don't know) at least..... two to three people a day, which isn't a lot, but it's a lot when you're busy.

JB Mmmn. And that's out of how many patients roughly? (Just a sort of impression)

Dr 5 Em. Well on my full days I see about 30 to 40 ... to the last patient, 30 to 40 patients. Actually I see more than that, I see 40+ patients.

JB So a lot more than they should - can you say a bit more about that?

Dr 5 Well, well it always intrigues me why some people come (well, it's not just about things like this), but why some people come to the doctor and others just wouldn't have dreamt of coming, they would just wait to see what happened, or they'd have gone to the chemist or something. And so it does take up ... even though it's quite often when somebody comes in with something like this you think "Oh great!" - quite quickly ... you can get rid of them quickly! But they're actually taking up a slot where you could be doing something a lot more useful. And I suppose it irritates ... it's also I find it a bit irritating as well. Like, today, Saturday morning, very irritated by it, whereas perhaps you know during the week you think "Oh well, I can just give them a bit of advice and hopefully they won't come back."

As in the example above, doctors debated the legitimacy of URTI consultations and tended to link 'minor illness' consultations to negative sentiments about their work (see also chapter 1), for example:

Interview Dr 9, lines 105-112

JB Yeah, and how are you feeling about your workload generally?

Dr 9 Hard. I'm really, really tired at the end of the day, absolutely shattered.
[...]

JB And thinking about cough and cold or sort of self-limiting things, is there a relationship between how tired you feel and sort of the nature of the workload, if you like?

Dr 9 Yes. Oh, yes, of course. Yeah, yeah. No, I mean, I've got a cold at the moment and I'm feeling feverish and I've got a headache and that. Erm. You have to be really around it and I think there are times when I'm less patient than at other times, but probably I just go slower, because I'm trying consciously to make myself more ... or less ... trying to make myself less tired and sort of irritable and what not. So just by watching out for that, it just makes me go a lot slower, so I was 45 minutes late for most of the morning. So ... but just because I was just thinking I'm just exhausted and I needed to go slow. But, yeah. No, there are days when you think, oh God - what have I done? *(laughs)*

JB What in your …?

Dr 9 In the (end) you might have been a bit … you just didn't have the energy and the effort to kind of really explore somebody's concerns when they come in with another cold.

GRIN Cartoon 3

Whilst URTI consultations were often talked about in negative terms, doctors sought reasons for attendance which could be seen as legitimate and would therefore justify the consultation, for example underlying emotional concerns:

Interview Dr 12, lines 19-20

JB So, in thinking about patients consulting with URTIs, what kind of springs to mind?

Dr 12 I mean sometimes you think kind of irri-… well, no, you see, I think there's a stereotype of a doctor feeling irritated because people have come with URTIs and they're wasting our time. But I think because they're less often now, that isn't what springs to mind really. Sometimes it's "Phew, this might be a really quick consultation, so I can catch up on being behind." Although now we've got 15 minute consultations, there's less of that feeling. Erm. *(pause)* Sometimes, although perhaps not as often as I would like to … you know, I'd be lying if I said it wasn't very often, but sometimes there's that 'why have they come?' sort of feeling. You know, like could it be that there's something else going on, some underlying kind of emotional thing. But I don't … I'm not … yeah, I'm not perhaps as good at that as I'd like to be. Sometimes there's irritation because it feels like there's a sort of … there's a mixture of a language problem and a certain amount of sort of helplessness of the patient, that just makes you feel like, oh, God! I can't deal with this! Sometimes I get really cross actually, because I think the patient's just going to give me their cold; there's an element of that I think!

For doctors, another legitimate reason for consulting was the possibility that URTI symptoms could indicate serious underlying medical problems. Trying to exclude these (and work out what people want) represented 'bread and butter general practice' for this GP:

Interview Dr 11, lines 64-69

JB [...] thinking about adults with uncomplicated coughs and colds, how does that relate to appropriateness really? Do you see it as part of your role?

Dr 11 Well, I think, erm ... er. Yeah, I think it is part of the role. Obviously it's a role ... part of the role of a GP to be dealing with those things, and, erm, it's an important skill, because, erm, you know, in amongst the patients who present with self-limiting viral infections, er, there are people with illnesses that are certainly not self-limiting. A chap came *(end of side A)* ... erm, who'd had pneumonia, so you know, he was an otherwise fit, healthy, erm, you know, wise, professional bloke who'd presented about, I don't know, two weeks previously, er, with a cough, and, erm, er ... he'd had a pneumonia. So, you know, he could have easily have been dismissed as someone who'd had a viral upper respiratory, er, you know, bronchitic infection and then, erm, there's plenty of tuberculosis in, er ... in Hackney and it's quite clear that most people, er ... many people diagnosed with tuberculosis, er, have previously seen the GP and either not been prescribed anything or been prescribed a course of routine antibiotics. Er. So, you know, clearly these things are rarer than, erm, upper respiratory viral infections, but that's part of, er, the challenge of being a GP in a place like Hackney. So, if you could be confident that every single one had a self-limiting upper viral respiratory infection then, erm, you know, that would probably not demand much thought or clinical skills, really. So, you know, I see it as, erm, appropriate and, er, challenging. *(laughs)*

JB Yeah. Challenging because of clinical issues do you think or ...?

Dr 11 Well, yeah. I think that, yeah, clinical issues. Erm. Er. I think they're quite, erm ... often they're quite, er ... not difficult consultations, but they're always consultations that you have to think about because not just whether you're missing something more serious, but, erm, as you said at the beginning, people come with, er ... with different expectations and, you know, part of the challenge is to work out what people want and to try to communicate effectively. You know, it's bread and butter general practice, really.

However, 'trivial' illness does not seem to demand the skills that 'real' illness does:

Interview Dr 4, lines 151-157

JB OK. Does that mean that URTIs are not really using your skills?

Dr 4 Well I think they're using them less. I tend to fall back on things, like ... I think they are using them less. I mean I'm still using diagnostic skills but the thing is, you do a consultation so many times, don't you, that it doesn't it, becomes more spinal cord than brain[18]. You are using your clinical skills but if you listen to a normal chest ... no I don't think they are as clinically demanding as some consultations, like, you know, leg weakness or dizziness, or fit - I had a fit this morning, quite a difficult one - a fit or brain metastases and metastatic disease. I mean they are things that demand more clinical

[18] I.e. reflex rather than conscious. This is an example of doctor lingo which the doctor interviewee has assumed I will understand, putting us on a peer-peer footing (discussed in chapter 3)

skills. It's funny actually you know but I'd say probably the URTIs, the tiny things are ones I've got less experience of really. I know a girl came in with a twitching face today, and it just looked like she just had a nervous twitch. I got all nervous because I'd never actually managed one, even though I knew what the answer was, I had to go and ask A - *(laughs)* to check - do you know what I mean? So actually I've got less experience of the trivial medicine.

JB Do you feel better trained for the more serious ones?

Dr 4 Yes, I do. Yeah, that's because you get trained in hospitals, don't you, and they don't know anything about general practice. *(laughs)* Em. Yes, I do. And also that's really what I did for most of my career so far, even though I'm quite young, you know, I'm only 34. I haven't been working for that long.

As these examples show, 'appropriateness' was shaped by a variety of factors: doctors deemed consulting on a Saturday morning more inappropriate than at other times:

Interview Dr 5, lines 321-5

Dr 5 He wanted the pink medicine or the red medicine that Dr X had given him 10 years ago. But I was a bit irritated I think.

JB Yes, you seemed to be.

Dr 5 Well I was probably because he was the first person of a long list on a Saturday morning and some of them were quite legitimate but it's never a good time to catch the doctor, I don't think, Saturday mornings, when they're feeling a bit irritated. I probably said to him at the beginning "How long have you had this?" "Three weeks" "So three weeks, why have you come in on a Saturday morning?" And then they usually say "Well because I work!" "I say well lots of our patients work and if everybody came in on a Saturday, I'd have 1,000 more patients sitting out there waiting to see me today." So I do get a bit irritated! *(laughs)* Although I don't think that's ... sometimes I think, well, you know, that's fair enough, showing your irritation. Maybe not always, maybe that's not a good thing.

These quotations illustrate discourses within medicine about whether URTI consultations represent 'proper' work for doctors because of their 'trivial' nature. Policy interventions reflect this uncertainty: minor illness is seen as one area where pressure on GPs might be relieved, for example encouraging patients to self-care and/or using nurses and other health workers to take on some of the work-load (Butler et al. 2001; Rees & Butler 2001).

Interventions to reduce prescribing and GP workload

Sharing workload

Nurses' roles are extending in primary care and minor illness is one area which is seen as suitable for nurses to take responsibility as independent practitioners, diagnosing and prescribing within 'patient group directive' guidelines (Cox & Jones 2000; DTB

2006). The employment of nurses to help manage minor illness in primary care seems likely to reduce doctors' workload (Pritchard & Kendrick 2001) but national figures assessing the impact of changing work practices are not available.

The Pharmacy First initiative in the UK aimed to encourage people to consult pharmacists instead of doctors or nurses for advice about minor illness (DOH 2000). It is not known whether this has impacted upon GP workload, but an evaluation of a trial intervention of pharmacy advice and prescribing indicated that patients preferred to see GPs rather than pharmacists for ailments such as cough or sore throat, so this type of intervention may not impact on GP consultation rates (Bojke et al. 2004). Doctors commented that they were seeing fewer patients with URTIs than in years gone by:

Interview Dr 12, lines 5-8

JB And you thought there were fewer [URTI consultations] these days?

Dr 12 Definitely. [..] it is surprising, yeah, how few of them present with URTIs; there seem to be an awful lot of people just self managing. Erm. And for a while we had a Nurse Practitioner see all our emergency patients for about a year, a guy called K** and he ... so when I first worked there, I wasn't seeing many URTIs, because K** was seeing them, and I don't know whether he had a particular influence on patients' expectations, you know. I suppose one could sort of theorise that they didn't like seeing a nurse and therefore it put them off even coming with an URTI. I don't know; I'm absolutely ... obviously it's total speculation. Or he just really educated them very well about self management so they didn't need to come back. Or whether he had no part to play in that process, but certainly we don't see very many, I don't think, relatively, compared to years ago.

JB Mmmn. And you mentioned Pharmacy First?

Dr 12 Yeah, which is fantastic. When it ... because I ... when Pharmacy First was first being piloted in south east Hackney, I was kind of passionately jealous of the doctors in south east Hackney who had access to it! *(little laugh)* But as soon as it became available in Hackney - in our bit of Hackney - we sort of signed up for it and the reception were brilliant at telling patients about it, and giving them the leaflet and giving them the NHS number and, you know, doing all that stuff. So, I mean, again one doesn't know who's using it but I have that ... we have that impression that there's a whole bunch of patients using it and going through the pharmacy and not coming to us. That's certainly my hunch.

NHS Direct was set up in 1998/9. This is a telephone service staffed by nurses, and is designed to provide triage to appropriate services, medical advice and health information (DOH 1997) although this initiative does not seem to have impacted upon GP consultation rates (Chapman et al. 2002). Neither doctors nor patients in this study mentioned NHS Direct.

There are ongoing initiatives supported by public health policy to educate both doctors and patients in order to reduce consultation rates for self-limiting symptoms and to

reduce antibiotic prescribing rates (Arroll et al. 2003; Brown & Goel 1996; Subgroup of Antimicrobial Resistance & DOH 1998). Interventions to reduce antibiotic prescribing have been two pronged: 1) exhortation of doctors to behave more rationally, in other words not prescribe antibiotics if these are ineffective and 2) education campaigns to inform patients that antibiotics are ineffective for self-limiting infections, and that visits to health professionals are therefore unnecessary.

Doctor education to reduce antibiotic prescribing

Initiatives targeted at doctors draw upon rational arguments about the ineffectiveness of antibiotics, for example distributing guidelines for antibiotic prescribing (Flottorp et al. 2003; SIGN 1999). GP practices also receive feedback on their prescribing via reports from the Prescription Pricing Authority (PPA 2005). Incentives are intended to encourage doctors to adhere to national and local priorities for reducing the prescription of antibiotics and of 'drugs of limited clinical value' such as cough medicines (BMA & RPSGB 2001). Educational initiatives advocate consultation skills training as one way of developing skills to negotiate patient expectations (Rollnick et al. 2002). These initiatives are very much 'evidence-based' (Sackett et al. 1997). However, professionalism was characterised as more than adhering to 'the evidence' for doctors I interviewed:

Interview Dr 4, lines 163-5

JB About antibiotics, do you feel there's pressures to reduce prescribing?

Dr 4 Yes, what I don't like is when I go to meetings and there's a PCT sort of pharmacist (this has happened to me a few times) talking about evidence, say for example Sweden ... Norway (I think they quote quite a lot), where they say "They don't use antibiotics in Norway, so you don't use them here." And I don't like that, that's not clinical, it's not good medicine, it's not ... you know, it's kind of taking a different country's health beliefs and cultures and doctors and illnesses and transposing them to here; I don't think you can always be sure, I don't think you can ... I don't like that, I don't like that at all. I don't think it's very clinical. I'm very aware of what's going on with antibiotics in terms of resistance globally and where we are. But that's more from listening to Radio 4 than actually, em ... but, em ... so I know that we probably have over-prescribed and I think we are prescribing less, which is good, and I think patients are less ... well, informed patients are less willing to ... but I don't think you can be black and white about it at all, I really don't think. I think you've just got to judge every clinical situation. Things like days ... like they say for Trimethoprim, three doses of Trimethoprim, I mean - what if the patient's got ... had a pyrexia for the last four days, you're not going to give them three doses, are you? You're going to judge it on the ... you're not going to follow a guideline. The interesting thing is if you send anyone to the microbiologist in my experience, they get the highest dose, most unusual antibiotic. It's all contradictory! I just trust myself really. I mean I have to, because I'm seeing the patient! *(laughs)*

Patient education to reduce demand for antibiotics

The Department of Health (DOH) has launched several campaigns to try and encourage self-care for URTIs, one of which used the character 'Andy-biotic' to educate people about the appropriateness of antibiotics for URTIs (see DOH poster below and Appendix 9) (Doctor Patient Partnership 2001). These initiatives are premised on the assumption that patients misunderstand the normal presentation of a URTI and the effectiveness of antibiotics (Mainous, III et al. 1997) and that supplying information will lead to change in consulting behaviour (McCormack et al. 2003).

DOH poster 1

The messages in this DOH campaign are didactic and negative, and patients are implicitly portrayed as demanding. The capsule acts as a metonym for (male) medical science (van der Geest & Reynolds White 1989), and messages are contradictory in encouraging self-care, but at the same time retaining medical authority as the final arbiter ('your doctor will prescribe antibiotics if you really do need them'). The posters aim to educate the general public about the appropriate use of antibiotics. However, Vingilis et al found that consultation behaviour was not related to inaccurate knowledge about colds and flu (Vingilis et al. 1999) and booklets about the management of minor

illness sent to patients in the post had very little effect on subsequent consultation rates for minor illness or out-of-hours consultations (Heaney et al. 2001; Little et al. 2001). Doctors I interviewed generally concurred with the idea that patient education could reduce demand in general practice, for example:

Interview Dr 6, lines 3-4

JB So URTI as a research topic might seem a surprising one, I just wondered what kind of thoughts first come to your mind?

Dr 6 Erm. I think it's a very common problem in general practice, seeing people with URTIs, erm, and I think we could probably reduce the number of consultations by educating people better about, er, when they need to come. I think a lot of people have got a fairly good handle anyway and the, erm ... that campaign a few years ago about, erm, antibiotics don't work for colds and coughs - know what I mean? - and the little dripping nose, well, I liked that advert; I don't know how effective it was. But, erm ... erm, so that's on the one hand, er, and, you know, it would be nice if people knew that it wasn't anything to worry about. But on the other hand, erm, I do quite like seeing people with URTIs because it is a relatively quick, easy problem and, erm, a lot of the time, these problems are going to Nurse Practitioners now, which is ... which is, you know, good, because we can see the more complicated things. But in a way, I think, erm, it's nice to have some lighter things to see as well, because, er ...

However, understanding the biomedical nature of their illness did not seem particularly important to patients I interviewed (see also 'Researching colds as a topic' in chapter 3):

Interview Pt K, lines 94-109

JB So he said it was a viral infection?

Pt K Uh huh.

JB Did that make sense to you?

Pt K Erm. I guess so. It was an infection organised, erm, originated by a virus, yes, I guess so, really.

JB And was that what you thought it was?

Pt K I just thought it was the flu. Classic flu and I was expecting something to cure it, that's all, it's much more simple, but, erm, fine. Even though he said that for that, erm, he couldn't give me antibiotics, so I presume anything else, so, erm, fine. I believed him. So, if he tells me there is nothing else you need to wait until it goes, then I wait. I'm a very patient! *(laughs)*

JB Yes! So, it doesn't much matter whether it's a virus or something else, or ...? Is that what you're saying?

Pt K Erm. Well, I ... to be entirely honest, it doesn't matter to me. I just want to know what it is and whether it's going to be curable or cured. And, erm, if he says it's going to go away, fine. Erm. Let's just wait.

JB Uh huh. Yes. Because I think doctors use that explanation a lot, they'll say, well, it's a virus infection ...

Pt K Right.

JB ... but I'm not sure that that means much. It's in all the medical text books, what a virus is, but, erm, for patients, I'm not sure that it's really that helpful in a way.

Pt K Well, I ... I don't know. I think ... I think probably it helps knowing more about what type of disease you have, and, erm ... but then, erm, it's just ... I think that in a way, the more I know about that disease, whichever disease it is, it's the less responsibility that I take off the hands of the doctor and erm, which, erm ... you know, might be the aim at the end of the day, but I don't think that I'm qualified enough as to be certain whether it's a viral infection therefore I'm not going to go next time or it is X, and therefore I have to go. I think it's not up to me, to be entirely honest.

[8 lines omitted]

So I guess, I don't know. Once again, I just say I'm not qualified for that. I don't want to say that, and this might come over as strong, but I don't want to have that responsibility, I don't want to, because I haven't studied for that. If I wanted to know everything about the whole, that I have, I would have studied and therefore I have no need in going to the doctor. But I have not, trust them because they are far more qualified than I am, and that's why I go to the doctors. That's the way I see it. But if someone will give me the opposite arguments, I might start to understand it and work around it.

JB Yes. And he didn't actually say this, but some doctors land up explaining the difference between a virus and a bacteria. Does that mean anything to you, the distinction between the two?

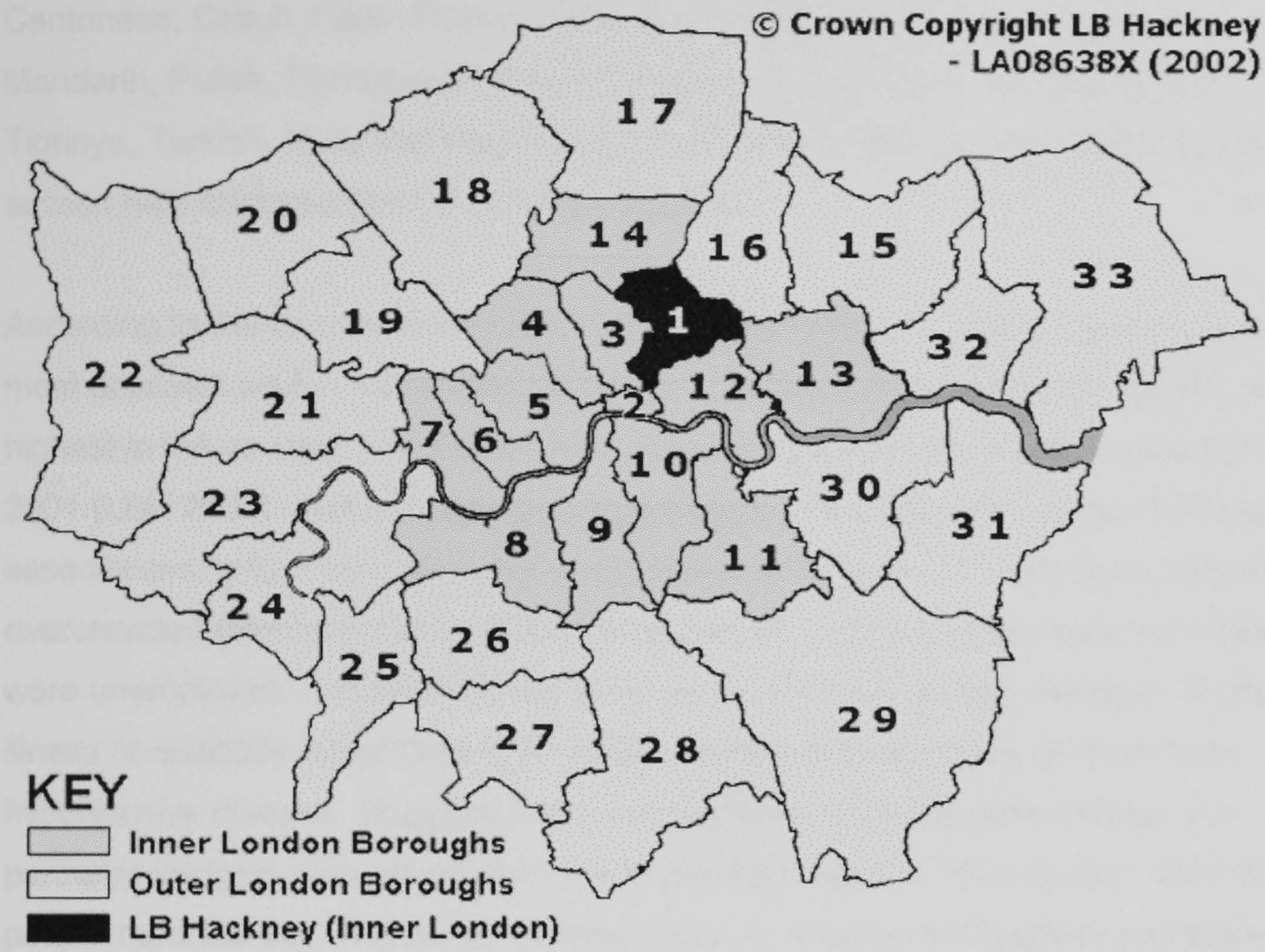
Pt K At the moment I don't know what the difference is, to be entirely honest. But, erm, I think I've been explained before, not by him, because it was the first time that I saw him, and I think probably I think I have been explained actually, but, erm, I don't remember to be entirely honest.

The patient in the example above links knowledge about illness with the responsibility to judge its seriousness, and he positions this very much as the doctor's job and not his. The doctor expressed a different view of respective responsibilities, and I chose this patient's consultation for detailed case study (chapter 6).

Health policy in the UK sets URTI consultations in the context of rational, evidence-based arguments about the ineffectiveness of antibiotics for URTI, positioning 'high consultation rates' and 'over-prescribing' as linked with a lack of knowledge on the part of both patients and doctors. Educational campaigns appeal to rational argument to change behaviour. Policy initiatives to shift URTI consultations to other professionals reflect doubt about whether URTIs represent 'proper' work for doctors.

Study Setting: Hackney

The study involves 16 doctors and 33 patients from six GP practices in the London Borough of Hackney, East London, UK.



The London Borough of Hackney had a population of about 210,000 in 2004, and a younger than average population profile; three quarters were under 45 years old compared with 61% in England and Wales (Mountford et al. 2004). Women outnumbered men between the ages of 20 and 40 and above 70 years old. The population is geographically mobile; in a MORI survey, 19% had lived in Hackney for under 5 years (LBH 2005).

Historically, Hackney has attracted a diverse range of immigrants, refugees and asylum seekers from all over the world. According to the Office of National Statistics 2001 Census estimates, almost 40% of the population was from ethnic minority groups; the largest group was categorised as black African or black Caribbean (22%) (Mountford et al. 2004). Nearly half gave their religion as Christian, with 19% having no religion, 14% Muslim and 5% Jewish. Stamford Hill is home to the largest Jewish community in Europe, while the Vietnamese and Turkish speaking communities are also strongly established in the borough. Over 1% of residents were asylum seekers. Ethnic minority

groups in the borough have a younger age structure than the white population, with 50% of children under 4 years of age coming from ethnic communities other than white. A survey in Hackney schools showed that the total number of languages spoken other than English was 88 (LBH 2005). The City and Hackney Primary Care Trust provides language advocacy services for local health services, with health advocates for users of the following languages: Albanian, Amharic, Arabic, British Sign Language, Bengali, Cantonese, Czech, Farsi, French, Gujarati, Hebrew/Yiddish, Hindi, Kurmanci, Mandarin, Polish, Portuguese, Punjabi, Russian, Serbo-Croat, Somali, Spanish, Tigrinya, Turkish, Urdu and Vietnamese. Practitioners can also use 'Language-Line' to access help from speakers of other languages.

According to the Government Index of Deprivation 2000, Hackney was the second most deprived area in the country. Hackney's teenage pregnancy rate was the fourth highest in the country, and almost 40% of households had an income below £15,000 in 2001 (LBH 2005). Half of Hackney's households rented from the council or housing associations; only a third were owner-occupied, and nearly 10% of households were overcrowded (Mountford et al. 2004). One in eight of working-age Hackney residents were unemployed, and another one in ten were not seeking work because of long-term illness or disability (Mountford et al. 2004). There were high rates of death from hypertensive disease, diabetes, infectious diseases, epilepsy, tuberculosis and perinatal mortality (Mountford et al. 2004) and high rates of HIV infection. One in three people reported smoking which is higher than the average for England and Wales but reported consumption of alcohol was lower than average. Hackney's demographic profile, with a relatively young population, its ethnic diversity, geographically mobile population and poor average health indices is similar to several other inner city London boroughs, but differs markedly from the UK mean.

Doctors linked high patient demand with Hackney's socio-economic climate, with implications for doctors' roles:

Interview Dr 5, lines 203-13

JB [..] are colds something you see as part of your role?

Dr 5 Well I think they are in Hackney because of the lack of social networks that people have and the is(olation?)..... I think, you know. Whereas ... and lack of education I think. You know, a lot of ... most of my friends wouldn't dream of going to a doctor with a cold, or you know ... but because they have learnt from their own childhood or their parents never took them to see the doctor or whatever (not true of all my friends actually), but you know ... so I think it's something that you learn yourself and if your parents were taking you to the doctor constantly with a cold, you're probably going to take your child constantly to the doctor with a cold, until the doctor says "Well actually, you don't actually need to come with this because it's just a normal part of childhood or a normal part of being 17 or 18 or whatever age you are."

JB Yes. So it's part of your role in Hackney?

Dr 5 Yes, I think if I was a GP in Suffolk *(end of side A)* Yes I think if I was a GP in Suffolk or Berkshire, you probably wouldn't be dealing with this, because your clientele is different, but we have a very highly dependent group of patients, who come in with all sorts of things, you know, just when they've like vomited once "Oooh, get round to the doctors!" You know, rather than vomited once, "Well, let's wait and see if I'm still vomiting in two days' time" or whatever.

JB Yes. And how does that make you feel?

Dr 5 Well, I think because I'm in Hackney, you have to take it and just ... you know, I don't take it ... I mean, I think that's my role probably. I mean a lot of what we do isn't about curing people, it's about acting as an advocate or to because there's the ease of access to us, we do things that otherwise friends, neighbours, vicars, you know, the religious priests or whatever would be doing in other cultures and in other places.

I turn now to a description of the GP practices and of study participants.

The GP practices

Five of the GP practices were group practices and one was single-handed. The practices all served populations which were diverse in terms of ethnicity and socio-economic indices since there are pockets of multiple deprivation alongside more wealthy neighbourhoods in Hackney (Griffiths 1996). Four of the six practices held regular appointment sessions during which Turkish health advocates were available.

I attended surgeries for morning, afternoon and evening sessions, and Saturday mornings in surgeries which held these emergency drop-in sessions[19]. I did not go to surgery sessions which were entirely pre-booked because of the low likelihood that people with acute URTIs would come to these appointments. I recruited thirty three patients to the study over twenty nine surgery sessions. Five people with URTI symptoms declined to be in the study without giving specific reasons. A further seven people with URTI symptoms were ineligible because of difficulties with communicating in English.

[19] Saturday morning emergency drop-in surgeries have since been phased out and replaced by an out-of-hours service based in a local hospital

Participants

The literature suggests that demographic variables are associated with differences in either consulting behaviour or outcomes in URTI consultations and this was why I used these criteria to select participants (see chapters 1 and 3). As I have discussed in chapter 2, discursive approaches to interaction focus on identities which are salient for participants rather than on researcher-defined categories. I therefore present selected demographic details about the people who participated in order to show the extent to which the sampling succeeded in recruiting a varied sample, rather than to claim that these attributes are necessarily the most relevant for understanding interaction between participating doctors and patients. Quotations from interviews illustrate whether participants themselves felt that demographic variables were relevant to URTI consultations. Although participants were selected using demographic criteria, I used theoretical criteria to further sample the data (see chapter 3): in chapter 5, I sample all 'cough clips' and in chapter 6, I choose a case study using a combination of demographic characteristics and interactional criteria: a young man with 'straightforward' URTI symptoms who was refused antibiotics. I discuss sampling and the 'transferability' of findings in chapter 7.

The doctors

The 16 doctors varied in age from 28 years old to 54, with most being in their 30s and 40s. The youngest was a GP registrar, and the oldest had worked in general practice for 27 years. Eleven of the doctors were women (70%) and five were men (30%). Eleven were white British (two identifying as white Jewish) (70%), one Anglo-Irish, one Indian British, one Middle Eastern British, one German and one South African Jewish[20]. One doctor felt that her own experience of racism and prejudice meant that she felt more empathy with some groups of patients. However, doctors did not see their own gender or ethnicity as particularly important with respect to URTI consultations.

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[20] There are important methodological, theoretical and ideological reservations about the uncritical use of ethnicity as a demographic variable in medical research (Bhopal 1997; Senior & Bhopal 1994). Participants in this study labelled their ethnicity in a variety of ways, for example in terms of religious affiliation (Jewish, Muslim), country of birth, and/or description of skin colour (e.g. black British). I do not analyse linguistic variation in either doctor or patient talk (Roberts et al. 2005) but have used crude categorisations of ethnicity similar to the Office of National Statistics Census categories (Mountford et al. 2004) in order to show that the sample recruited appeared to be culturally diverse, as would be expected in East London.

Ten of the doctors were part-time[21] (63%); 4 of these were GP partners (25%), 4 were GP assistants (25%), one was a locum and one a GP registrar. Five doctors were full-time (30%); 3 were GP partners, one was a locum, and one a GP registrar. One other doctor moved from being a full-time locum doctor to being a part-time partner during the course of data collection. Doctor interviewees felt that their employment status, their experience in general practice and length of time in a particular practice impacted on URTI consultations. For example, GPs agreed that the more established doctors saw a smaller proportion of patients with URTIs since their appointment slots tended to be filled with 'regular' patients. Younger, more recently trained doctors talked more in terms of 'evidence-based practice' than did older doctors, for example:

Interview Dr 6, lines 56-62

Dr 6 Erm. No, I don't know what the effectiveness is for steam. I must say I haven't ... I haven't really. I supposed if somebody is complaining of feeling really bunged up, I might do, but it's not something I routinely advise, and I don't know there's a lot of evidence for fluids either. So I think I used to say it, and then I read somewhere there wasn't a lot of evidence for it, so, erm, I don't ... no, I used to say make sure you have plenty to drink but I think as long as somebody's is, you know, not dehydrated, as long as they're normally hydrated, I don't think there's any evidence of fluids making any difference, so that's not something I mention any more. It's really paracetamol, ibuprofen and your body will get better itself.

JB So you try to, erm, prescribe in a kind of evidence based way, do you?

Dr 6 Er.

JB Not really a role for kind of placebos?

Dr 6 Yeah, I do try and prescribe in an evidence based way. Erm. Placebos, I mean if people feel better, then they're feeling better, aren't they? But, I suppose it depends on how expensive they are and how likely they are to have side effects, and if somebody wants to go and buy a cough linctus, then ... then that's ... you know, that's fine by me, if they find it helpful, but I'm not really keen to spend NHS money doing it. I suppose they're not expensive but, erm ... erm, I think I've been brought up with a very evidence based mind set, so I'm reluctant to prescribe those things.

Part-time or full-time status also seemed to impact upon doctors' perceptions of their work: the part-time doctors were generally much more positive about their workload than full-time doctors. This part-time doctor said:

Interview Dr 7, lines 49-50

JB So a few general questions, I wanted to ask you how you feel in general about your job at the moment? So particularly thinking about things like workload and job satisfaction?

Dr 7 Well my workload's great at the moment! *(little laugh)* Because I've ... I've ... you know, I've gone onto not a full week; I'm doing five sessions which I'm going to possibly do a bit more, but at the moment I'm not doing. So it feels nice. Erm. Yeah, and I think

[21] i.e. working fewer than eight clinical sessions a week

that just influences everything because I feel I'm starting to settle into a new practice. Erm. And I feel I've got the time to do that, erm. Yeah, so I'm quite positive actually at the moment. *(little laugh)*

Doctors associated full-time status with greater pressure:

Interview Dr 6, lines 67-68

JB Great. OK. And how are you feeling about your job at the moment?

Dr 6 Er. *(nervous laugh)* Erm. Quite, er, worn out really. Erm. I do find it quite tough because we see a lot of patients and, erm ... er, their level of need around here is very high, so, erm ... I really enjoy it, but, erm, I find it quite exhausting as well and I think if I saw a lot fewer patients, I'd be so chuffed with my job, but as it is, I do find it quite exhausting. And, erm ... and it's difficult when you don't have as much time as you'd like to reflect and do things properly really, and it would be nice to be able to spend longer with patients generally and, erm, find out more about them and their problems and their worries and stuff and, er, have more time to explain things and do things properly. And, er, I think that's a bit of a shame, but er ... yeah, I do enjoy it but it's too busy.

The patients

Twenty two of the 33 participating patients were women (66%) and eleven were men (33%). Patients varied in age from 16 to 84 years, and were distributed across all age groups. Thirteen patients could be categorised as black African or black Caribbean (40%), ten as white British (30%), three as white Irish (9%), two as white European (6%), one as Turkish (3%), two as white Antipodean (6%), and two as of mixed heritage (6%). All spoke English fluently; for 6 people, English was not their first language. Most of the 13 patients interviewed had lived in the UK for many years (5 all of their lives; 4 for around 40 years; one for 16 years). One person had lived in the UK for 6 years and one for 5 years. Only one person was a very recent migrant, having been in the UK for 5 months.

I collected information on the employment status of twenty of the patients[22]. Thirteen people were in employment (65%) in a variety of jobs: personnel officer, cleaner, security guard, social worker, events organiser, legal secretary, telephonist, in marketing, editorial manager, office manager, teacher and two unknown. Two were full-time students, two had long-term illness or disability, two had retired and one was unemployed.

[22] Employment information is missing where participants were not interviewed and employment was not mentioned in consultation

As mentioned in the quotation on page 118, doctors linked demand upon services with Hackney's deprivation: patterns of consultation were seen as varying with age, gender, social class and ethnicity:

Interview Dr 4, lines 3-29

JB All right, so in your experience, how frequently do patients consult with coughs, colds, sore throats?

Dr 4 Em. It's definitely seasonal. Em. Obviously more in the winter. Definitely cultural, and age dependent. Em. And probably class dependent as well. I think the people who consult regularly anyway, people who are more often ... you know, regular consulters, they'll consult, just you know, for anything. People who rarely consult, like young men, come in quite ill and seem to want sympathy more than anything else. But in a morning surgery, in an average morning autumn/winter surgery, I'll probably see four, three or four. I think I saw this morning, I saw adults... 1 as you know, children.... 3.

JB Can you say a bit more about which types of people?

Dr 4 Age: children, mother's concerned (I know that's out of interest to your project). Quite a lot of sort of unsupported families are in and they quite often come for lots of things, I don't mind seeing them - not that I've got much experience with children, but I don't mind seeing them. Em. Culturally, I mean, just ... for example the Turkish just definitely consult more with it, no doubt about that.

JB Consult more overall?

Dr 4 Overall. Well I mean with minor things, but then they also don't speak the language, em, so I assume that kind of other sorts of resources are kind of, you know, quite difficult for them and quite often you know they ... you feel, well one feels like you're kind of like an early port of call; I don't know if that's true. The Turkish people I know are actually neighbours and stuff are, em ... seem to be a different population from the ones we see, so ... Em.

JB And class you mentioned?

Dr 4 Class ... middle classes are kind of very much aware I think anecdotally of sort of the whole *(loud noise obliterates)??* viruses and bacteria, and they're much more averse to antibiotics. Turkish people really want antibiotics all the time, I just have to fight with them not to, to say "No" quite often, particularly the young men - they get very cross. They also get different treatment, I think, from doctors in Turkey to here and that stands for lots of things, not just URTIs. So, you know, different health beliefs, different management, just a whole different picture, really.

The 'discursive context' for interactions includes assumptions about situations and participants (Edwards 1991). As in the example above, patients' demographic attributes (their 'transportable identities', see chapter 2) were prominent in doctors' categorisations of patients. Features of transportable identity were not usually directly evident in doctor-patient talk (see examples in chapters 2 and 6 for exceptions).

I now turn to a description of the topics and activities within the doctor-patient consultations:

The consultations

This next section sets the consultations in an ethnographic context to illustrate the institutional nature of the doctor-patient interactions. I shall give an overview of events in consultation, illustrated with extracts from consultations and quotations from doctor and patient interviews.

Day and time of day

Most of the URTI consultations took place in the mornings since the majority of the short-notice appointment slots were available at this time rather than in afternoons or evenings. The consultations were all held at the GP surgery premises, and patients were recruited from sessions throughout the week. Six URTI consultations took place on Saturday mornings in emergency drop-in surgeries held at practice premises. Consulting on a Saturday was associated with disputed legitimacy in several consultations (see example on page 65).

Interactions in consultation

A surprising proportion of doctors and patients had not met before (20/33). This is likely to be more common in the consultations of part-time and more temporary staff such as assistants, locums and GP registrars, and in appointment slots which are booked on the day instead of in advance, and also in a setting with high geographical mobility. Doctors and patients who *have* met before can draw upon shared knowledge about ongoing illness, the patient's wider social situation and knowledge of previous meetings (Stokes et al. 2005). There was more conversational, relational talk between those who knew each other than those who did not in this data set (Gafaranga 2002), with both doctors and patients asking after family members for example. Whether doctors and patients knew each other or not, URTIs represented new problems, entailing full explanation of problems (Robinson 2006).

The talk between doctors and patients captured on video-tape varied in length from 3 minutes to 35 minutes, with a median of 10 minutes. About half of the face-to-face talk was less than 10 minutes in length. Six of the 33 recorded consultations involved more

than one person: three people had young children with them in consultation, one had a son who was also a carer, one had her partner, and one consulted with his aunt. These companions were often not visible on the video-tape, but all contributed to the talk in consultation.

Topics and activities in consultation

Consultations all began with conversational greetings phases and all ended with conversational closing phases (Ainsworth-Vaughn 2001). In all consultations patients were invited to tell their story, then doctors gathered further information through asking questions and usually also a physical examination, and then diagnosis and treatment were discussed. These activities did not necessarily fall into neat sequential phases (ten Have 2002): for example doctors' questioning sometimes continued during physical examination, and new symptoms were raised and discussed at almost any time.

Consultations were quite long (median 10 minutes of face-to-face talk) and physical examinations took up an appreciable proportion of consultation time (see below). Most doctors' appointment slots were at ten minute intervals, so allowing for the time it would take to write in notes and call in the next person, this would have meant that doctors' appointments ran late. Doctors' responses to questions in interviews indicated that they perceived this research as a kind of peer-review (see chapter 3) so it is likely that consultations took longer and were more clinically thorough than they might have otherwise been without the video camera.

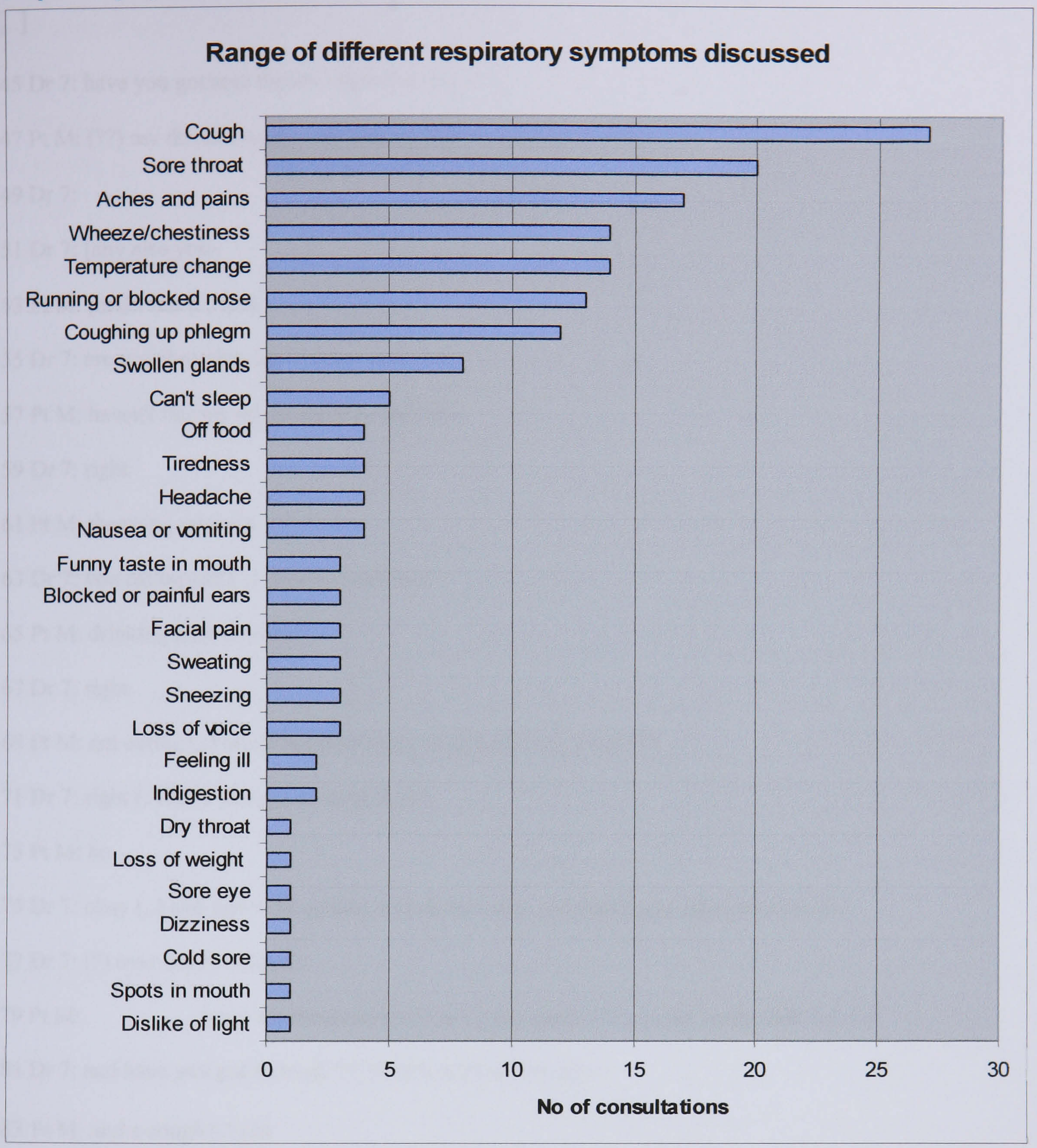
The institutional nature of interactions was obvious. For example, doctors interacted with computers in all of the consultations (Heath et al. 2000). Doctors referred to the computer to check name and address details, to check dates and details of past visits, to make notes during the consultation, and to issue prescriptions. Participants' use of tools and technologies has important consequences for interaction: for example, talk sometimes continued while doctors' attention was on the computer, but usually there were pauses in doctor-patient talk until doctors' body orientation and gaze returned to the patient (Greatbatch et al. 1995). My analysis therefore incorporates these dimensions of interaction in consultations (body conduct and interaction with tools and technologies) (see chapters 3, 5 and 6).

Symptoms discussed in consultation

Recent onset respiratory symptoms were discussed in all of the thirty three consultations (in other words, all were 'URTI consultations'). Seven people also had more long-standing respiratory problems such as asthma or chronic obstructive airways disease. Seven people raised separate non-respiratory reasons for consulting: a pregnancy test, pain and numbness in the hands, pain in the leg, diarrhoea and vomiting, facial numbness, and two people did not want to disclose other reasons for consulting. Only five people out of thirty three (15%) raised recent onset URTI symptoms alone and no other medical problems or separate agendas such as consulting with children, repeat prescriptions, or medical certificates. Most URTI consultations in this data set therefore appeared to be more complex than doctors' portrayal (see earlier in this chapter), and despite doctors' perception that routine, straightforward coughs and colds comprise a large part of their workload, only 5 out of these 33 consultations were 'simple URTIs'.

Many different symptoms were discussed in the thirty three consultations. The list below gives an idea of the range and variety of ailments which were troubling people, excluding symptoms which were treated in consultation as separate problems. All patients raised multiple symptoms in consultation, in unique combinations. There were not repeated patterns of symptoms which could be said to represent 'the common cold'.

Graph 1. Symptoms discussed in consultation



The following format of consultation talk was common, where different symptoms emerged over the course of fairly prolonged questioning, which perhaps suggests a search for a 'legitimate' reason for consulting (analysed in chapters 5 and 6):

Consultation Dr 7 and Pt M, lines 13-87

13 Pt M: yeah I'm having (..) well (.) flu-like symptoms since last week Tuesday

15 Dr 7: okay

17 Pt M: so I took some time off work but (.) yesterday when I went back to work I didn't feel any better

19 Dr 7: right

21 Pt M: got a (..) s:ore throat (...) I'm just aching (1.6) that's about it (laugh) kk kk kk

[..]

45 Dr 7: have you got sore throat- what else did you-

47 Pt M: (??) my throat's really sore and my body's [aching (.) yeah

49 Dr 7: [aching

51 Dr 7: [any else you-

53 Pt M: [and I felt (..) sick

55 Dr 7: are you throwing up

57 Pt M: haven't thrown up yet but I do feel like

59 Dr 7: right

61 Pt M: throwing up yeah

63 Dr 7: you eating and (..) drinking and stuff

65 Pt M: drinking a lot of water

67 Dr 7: right

69 Pt M: not eating (..) much because I can't really taste my food (??)

71 Dr 7: right (..) have you got an appetite or-

73 Pt M: no

75 Dr 7: okay (..) and you were getting a bit better were you starting to eat a bit more or-

77 Dr 7: (?) over the [weekend

79 Pt M: [over the weekend (2.0) no (.) not really (laugh) not really .hhh KK KK

81 Dr 7: and have you got a cough ? (.) I hear a bit of a cough

83 Pt M: and a cough (.) yes

85 Dr 7: are you coughing stuff up ?

87 Pt M: mm hm

The patient describes her symptoms in line 21 (sore throat and aching) indicating with a pause and 'that's about it' that this is the end of her list. This is not taken as adequate by the doctor, who asks twice about any other symptoms (lines 45 and 51). Further symptoms are added to the list until the patient coughs, and this elicits a comment from the doctor and questions about the nature of the cough, suggesting that cough is of more medical significance than the previous symptoms. I discuss this data extract in more detail in chapter 5.

Medical training teaches that presentation with a minor symptom (classically a sore throat) can be a prelude to a hidden agenda, often a psycho-social problem (Balint 1957): worries about the significance of symptoms did sometimes surface in consultation or in later interviews (e.g. worries about cancer, meningitis or heart disease [data not presented]) but consultations did not generally follow the format of 'minor' symptoms being a pretext to address other 'real' underlying reasons for attending. URTI themselves seemed to be important topics of talk.

The most frequently mentioned symptom in URTI consultations was cough, and patients often coughed during consultations (as in the example above). One particular patient coughed only in the second half of the consultation, while the doctor was explaining his decision to refuse antibiotics. This captured my curiosity, and I wondered whether this patient was coughing as a way of resisting the treatment suggestion. I present a systematic analysis of patients' coughing in chapter 5.

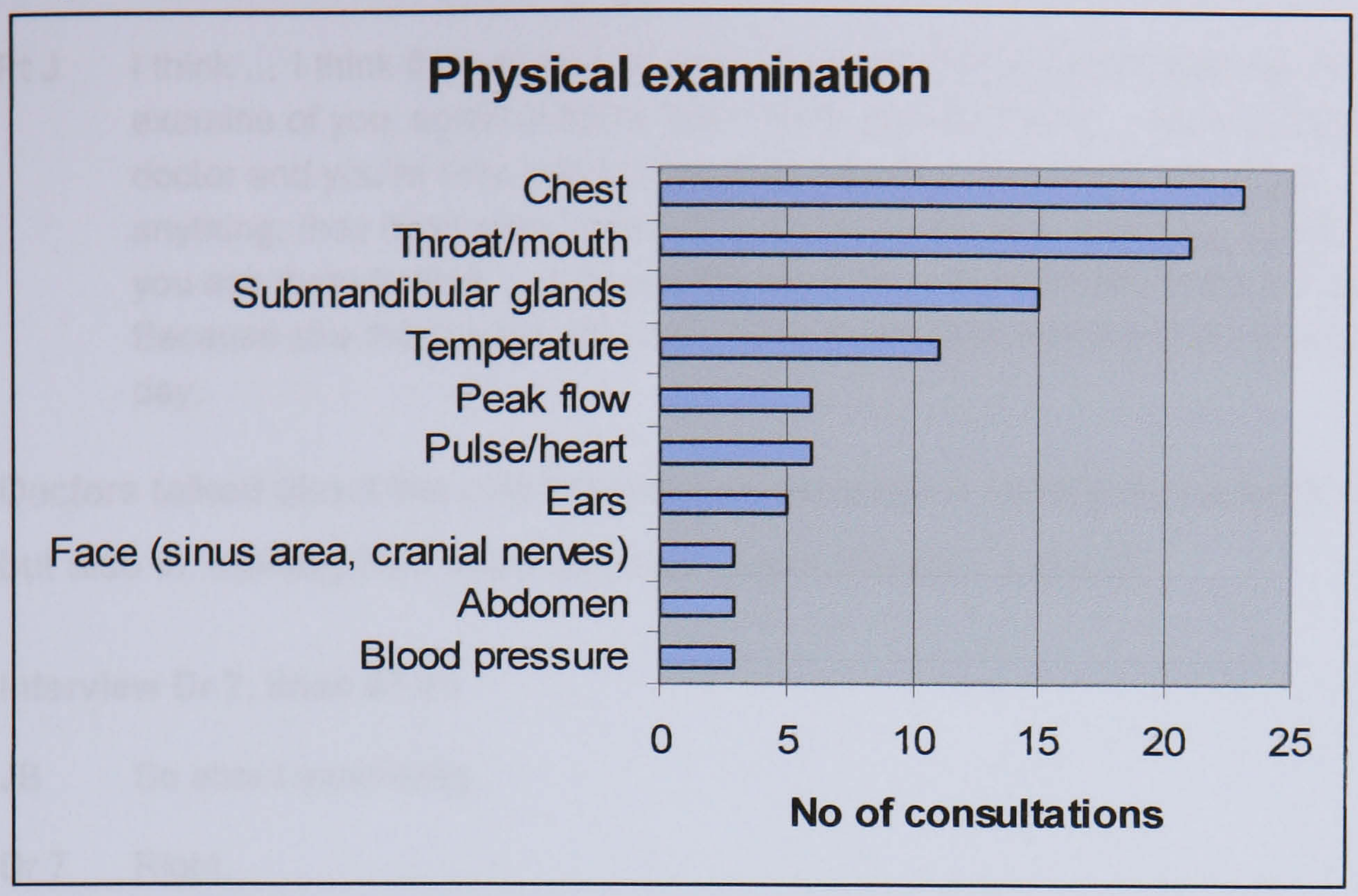
There was a mis-match between patients' and doctors' diagnostic labels: patients referred to their illnesses as flu, or 'flu-like' in about a third of consultations. In a few of these consultations the doctor concurred with this label, but in the other consultations doctors characterised patients' illness using terms which were much more vague, using language which tended to minimise the seriousness of the illness (see 'Doctors' diagnoses' below).

Physical examination

The transition to physical examination was usually clearly marked, with doctors signalling the end of the previous talk with verbal markers such as 'okay', 'right' or 'alright' and then either a direct question such as '*shall I just have a listen to your chest just to make sure that's clear*' (Dr 14) or an indirect request such as *'right what I want to do (..) is check your blood pressure'* (Dr 3). The transition to examination was occasionally marked non-verbally simply by getting out equipment.

About half of the physical examinations were captured on the video screen. For the off-screen examinations, it was usually possible to tell which part of the body was being examined from the doctors' talk. The doctors examined all but one of the patients, and examination almost always involved more than one element (see graph below):

Graph 2. Elements of physical examination



Doctors used a variety of equipment for physical examination: a torch for looking in mouths and ears, tongue depressors, an electronic thermometer, stethoscope for chest examination, peak flow meters to measure airways resistance, and cuffs to measure blood pressure. Several patients were unfamiliar with peak flow meters, and doctors spent some time explaining how to exhale adequately. Doctors occasionally took throat swabs and ear swabs, and blood tests were organised for two people.

Most physical examinations took some time, especially for patients with restricted mobility or more than one problem to address. Most respiratory examinations were 1 to 3 minutes in length occupying an appreciable proportion of total consultation length (median 10 minutes). The shortest examination was under half a minute, involving inspection of the throat and submandibular glands[23] in a young person with a sore throat, cough and loss of voice. The longest took nearly seven minutes and involved examination of the chest and throat, and measurement of temperature, peak flow and blood pressure, interspersed with more talk about the patient's symptoms and also discussion of the diagnosis.

The physical examination seemed to be important to both doctors and patients. One patient said:

Interview Pt J, lines 192-4

Pt J Again, I think every doctor … I think every doctor varies; I think no two doctors are the same, I think, anyway.

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[23] Submandibular glands are glands in the neck which may be swollen in throat infection

JB In what way? What do you mean?

Pt J I think … I think they all look at you in a different way and I think they're … some examine of you, some of them don't. And you see I was … some people, you go to a doctor and you're only in there five minutes; they don't even check you, they don't do anything; they don't even check your blood pressure or anything. They don't! Unless you ask them to do it … and you shouldn't have to ask them to do it, I don't think. Because she didn't even ask me … she didn't even check my blood pressure the other day.

Doctors talked about the role that examining plays in satisfying patients' expectations, but also in 'making their case stronger' (see chapters 2 and 6):

Interview Dr 7, lines 67-71

JB So about examining…

Dr 7 Right.

JB …do you feel it's sort of …?

Dr 7 Yeah. Yeah, I don't know really. Because I would … it's funny isn't it, because if she rang me and gave me the same things, I would be quite happy to say, well, look I really don't think I need to see you, from everything you've said. Let's give it a few more days, erm. You know, watch out … if you start coughing up some really nasty stuff, or … you know, you're … you feel really you're just getting worse and worse, or you're not eating at all, or whatever, then maybe come in and we'll have a look at you. But at the moment, I don't think it would make much difference. And you know I'd say, does that sound OK. I suppose, you know, I could say all that in the consultation, but because we're there, it's another … it's partly I think, you know, that there's an expectation in my mind that this is what patients want - whether they do or not … But also a bit of this makes my case stronger to say, you know, look I've heard what you've said and I've had a good look at you and I'm very happy.

Whereas perhaps if I sort of seemed to be not taking it as seriously, it's more likely she might be back sooner, whereas if I've had a really good look and even if it does take a while, erm. I mean, yeah, I think I would always do some level of examination, and certainly a kid … Actually I wouldn't … sometimes with children if they just tear … I know I shouldn't keep going on about this, but if they're tearing around the room and they're just obviously well, I would perhaps put that and say, look, they're well; I could listen to their chest and try and catch their temperature if I can get hold of her or him, and try and explain why I'm not doing it at least. So it's always there that this is something that I should consider. And in an adult I think I always would do something.

One doctor raised the symbolic importance of physical examination in the doctor-patient transaction:

Interview Dr 8, lines 111-114

JB Do you tend to examine everybody? I think you were saying that D*** sometimes doesn't, so (?) for you?

Dr 8 Yeah, I think I always examine patients, <u>always</u>. Erm. It's part of the mystery of the exchange and I think that there's something wrong if the patient's left the consulting room without any physical contact, so I believe it's part of the transaction and part of what you give as a doctor. That really special thing of being allowed to touch people when they take some of their clothes off, even though you don't know them very well.

JB Yeah. Can you say a bit more about that?

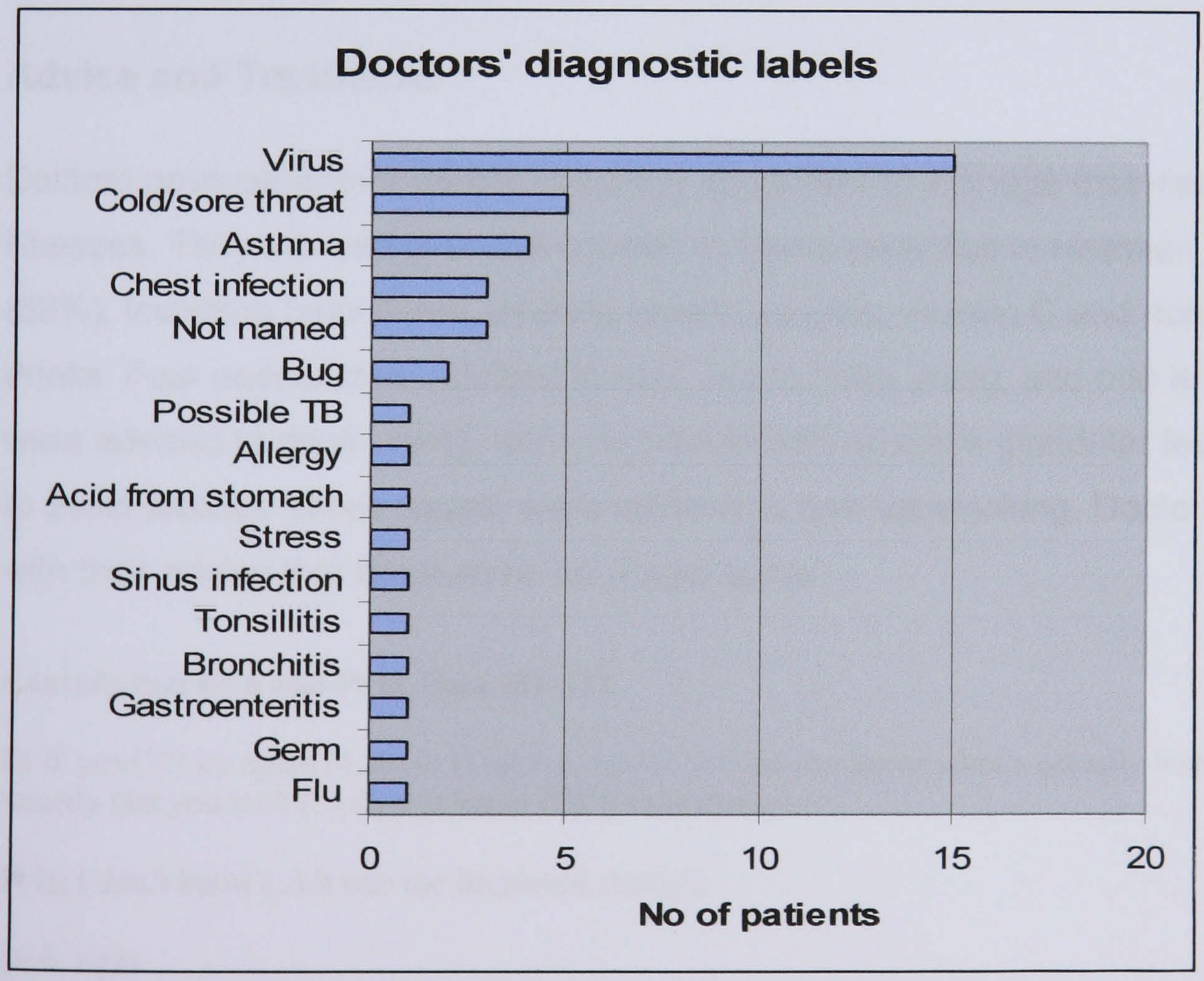
Dr 8 Well, it may be a paternalistic attitude, but I think it's something that, erm, is part of the therapeutic experience of going to the doctor, is touch and some personal closeness and that might be part of being examined. So it's part of the job as doctor; part of what helps patients. And, erm, sometimes that's much more important or equally as important as the prescribed medication. It's the transaction that goes on, so it's powerful. We know that many of the drugs are no more powerful or very little more powerful than placebo anyway.

I explore in chapter 6 the way that examination can be understood as a ritual which contributes to doctor identity.

Doctors' diagnoses

Patients' respiratory illnesses were given many different diagnostic labels, and these were generally vague terms in common use such as virus, germ, bug, flu, cold, sore throat, chest infection (Helman 1978) (see graph 3).

Graph 3. Doctors' diagnostic labels



Doctors tended to convey diagnoses in ways which minimise their seriousness, for example:

Consultation Dr 1 and Pt B

184 Dr 1: OK (.) its just (..) you're feeling a bit blocked up really (nodding whilst speaking) (..) Mmmm I think to be quite honest at the moment (.) what's probably happened is that you've picked up a bug (..) and that this time of the year there's [so much going around

186 Pt B: [yeah but you're talking about six eight weeks ago doctor

I discussed in chapter 2 the interactional function of 'minimising' language in doctors' online commentary during physical examination (Heritage & Stivers 1999). It also seems significant that doctors avoided technical, medical labels for illness, and drew on lay terms instead. I shall analyse the interactional significance of these features of doctors' talk in a detailed case study in chapter 6.

Medical Certificates

Three people requested certificates for absence from work (9%); doctors wrote certificates for two people and the other person was advised to write a self-certificate. Perhaps surprisingly, given the role of medical certificates in legitimising illness (see chapter 1), requests for certificates were not particularly associated with conflict between doctors and patients.

Advice and Treatment

Doctors gave patients a variety of advice about how to manage their respiratory illnesses. They advised over-the-counter or home remedies in nineteen consultations (58%), including pain-killers, inhaling steam, gargles, vitamin C and honey and lemon drinks. Four people were advised to rest, one to keep going, and one to exercise. Four were advised to drink plenty, and one person with possible glandular fever was advised to avoid alcohol. Three people were advised to give up smoking. Doctors conveyed with their advice that there were 'no magic cures':

Consultation Dr 6 and Pt H, lines 151-177

Dr 6: yes (??) try again (4.5) (Pt H taking jumper off) do you know what's actually inside the Beecham's remedy that you took (..) do you know if it's paracetamol or

Pt H: I don't know (..) it was the improved strength

Dr 6: right

Pt H: (??) I just remember

Dr 6: because these things generally they they they're to help with the symptoms they're not going to (..) there isn't anything which is going to cure it (.) it's um

Pt H: okay

Dr 6: it's just a matter of of (..) of time really (..) you said you just wanted something to to (..) shift the (..) to shift if off your chest didn't you (.) so (..) do you mean something just to help with the symptoms ra- you know (..) you- you know there's nothing that's going to cure it do you ?

Dr 6 it's that (..) it's just something that's going to get better by itself

Pt H: yes

Dr 6: but you just want something that's going to help (..) help get rid of it is that right ?

Pt H: yes (blood pressure machine whirring)

Dr 6: yes (..) unfortunately **there aren't really any magic cures** because em

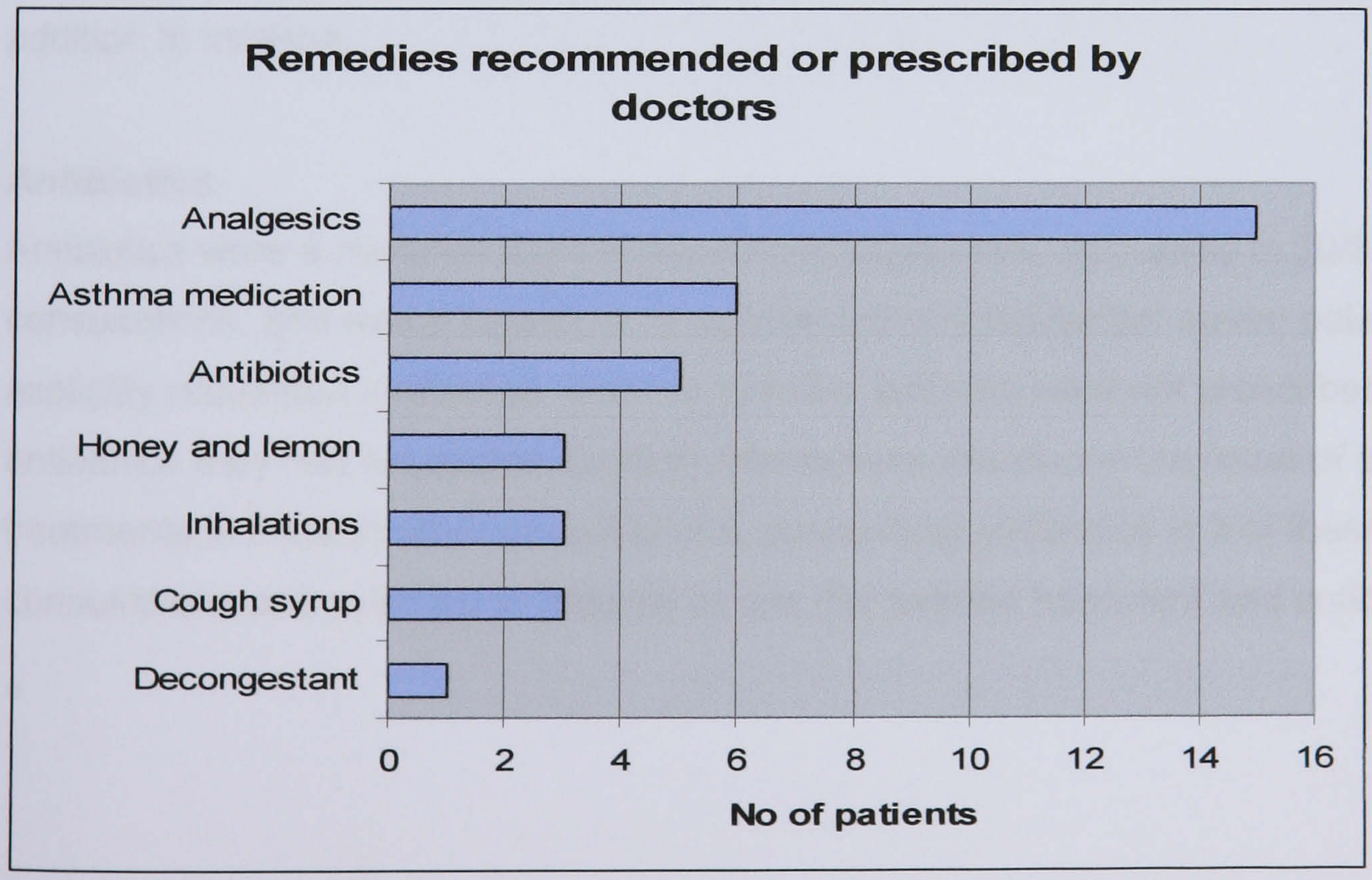
Pt H: (?oh)

Dr 6: yes (..) because cough linctuses haven't really been shown to be very effective (.) so we don't really prescribe those now (..) and really things like paracetamol and ibuprofen are the most effective at helping with the symptoms (..) because you know if you're feeling a bit (..) em just a bit groggy and unwell really um (10.5 seconds, blood pressure machine bleeping)

Medication prescribed

Sixteen people out of thirty three (48%) received no prescription for their respiratory symptoms. The other seventeen were prescribed a variety of medicines including pain-killers, antibiotics, inhalers and cold remedies (see below). Six people received prescriptions for other conditions or for other people.

Graph 4. Remedies recommended or prescribed



Pain-killers (analgesics) were commonly recommended or prescribed, but very few cough and cold remedies such as cough syrups or lozenges. Pain-killers, cough syrup and other cold remedies are available over-the-counter cheaper than on prescription in

the UK. These medicines were therefore generally issued on prescription only to people entitled to free prescriptions, in other words those under 18 in full-time education, those on benefit or those over 60/65. Cough and cold remedies are widely promoted for sale to the public (Johnson & Helman 2004) but have been designated 'drugs of limited clinical value' by the Audit Commission (Audit Commission 1994). Maintaining low levels of prescribing for these drugs is one of the aims of Primary Care Trust prescribing advisors.

Doctors endorsed over-the-counter pain-killers such as aspirin, ibuprofen and paracetamol for URTI symptoms in most consultations. Pain-killing medication was issued on prescription for five patients. One person received a prescription for an anaesthetic throat spray. One prescription for cough syrup was issued, and one for a decongestant. The person who received cough syrup was very wary of buying over-the-counter medicines in case these interacted with the Warfarin that she was taking.

Asthma medications

Asthma medications are available only on prescription in the UK. Inhalers were issued for 4 people (all of whom had used inhalers before, 3 for asthma, 1 for a cat allergy). Two people with marked wheeziness were given a nebuliser[24] in the surgery; these two people had ongoing respiratory conditions (asthma and chronic obstructive airways disease). One person with asthma was prescribed prednisolone steroid tablets in addition to inhalers.

Antibiotics

Antibiotics were a common topic of the doctor-patient talk, discussed in 20/33 (61%) of consultations, and was a source of disagreement in consultation: seven patients explicitly requested antibiotics, and five of these patients were not prescribed the antibiotics they had requested. Doctors themselves introduced the issue of antibiotic treatments in thirteen other consultations, prescribing antibiotics in 3 of these consultations and referring to hospital in one (for asthma treatment and antibiotics).

[24] Used to administer an aerosol of medication for inhalation

Doctors issued prescriptions for antibiotics for 5 people (15%) (4 Amoxycillin, 1 Clarithromycin), two of which were delayed prescriptions to be used at later dates if needed. In all of these cases, the patients' problems were designated viral in nature (and therefore not responsive to antibiotics), but particular factors swung the decision in favour of an antibiotic prescription, and these were clinical reasons: blood from the nose; crackles heard on chest examination; and concurrent medical problems (diabetes and a replaced heart valve). One of the people given a delayed antibiotic prescription was elderly (84) with restricted mobility; the other was younger (54) and was coughing up phlegm but with no apparent signs of chest infection on examination.

Doctors seemed to be assuming that patients expected antibiotics (Butler et al. 1998b) since they often raised and discussed antibiotics even if not mentioned by patients. Doctors tended to give rational, biomedical explanations for their treatment decisions, for example:

Consultation Dr 11 with Pt S and son, lines 263-87

Dr 11: I think it's one of those things that happens in the winter (.) I think you've probably picked up a er (..) er (..) a cough (.) a germ probably a virus infection

Pt S: mm

Dr 11: in the last few weeks (..) that's given you the- the er the- the cough

Pt S: mm

Dr 11: the good news is it's not right down on your chest (2.3)

Son: hm

Dr 11: so I suspect (..) that (..) your body's going to be able to fight it off naturally

Pt S: mm

Son: hm

Dr 11: you can take antibiotics for these sorts of things (..) generally (.) I don't think it would make much difference (..) I don't think it would make it go away any faster because I suspect this is a viral infection

Dr 11: .hh antibiotics are good at (..) helping you to (..) get rid of (..) bacterial infections (.) bad pneumonias and chest infections

Pt S: ah

Dr 11: but probably don't make much difference to these sorts of germs

Prescription of medication seemed to have particular symbolic importance for patients, perhaps representing a medical 'magic wand' (Johnson & Helman 2004; van der Geest & Reynolds White 1989). In the example below, this patient clearly associates doctors

with pills and being cured (van der Geest & Reynolds White 1989) and would have liked some medicine, even if 'the pill is just nothing' (he was not given a prescription):

Interview Pt K, lines 16-19

JB Yeah. So when you went to the doctors, did you have something in mind? What were you expecting?

Pt K Well, erm, when I go to the doctors, what I'm always expecting is for them to listen, erm, which is not very usual, unfortunately. And, erm, to listen and to understand that if I'm going to the doctor it's because I'm not feeling well, and you know sometimes we create ourselves too much expectation and they can not do what we want to do, but, erm, I would be very happy if they give me just a pill and say this is going to be for you to get better, even, you know, the pill is em just nothing. But, erm ... but this time he finally said that I didn't need anything, so I trusted him and went away, really! Feeling much better, that's true! *(laughs)*

JB You were hoping for some sort of medicine?

Pt K I was, yeah. I don't know whether it's because I associate doctors with medicines that when I go to a doctor's, I'm expecting a solution for a complaint really! *(little laugh)* So, yes, like basically, if you go to the doctors, they have to give you something good or something for you to get fine, but, erm ... but yes, I guess when I go to the doctors, I'm expecting to receive something. But it's more important and I really mean this, because I mentioned to you that I was before in another practice and I went to the doctor, because I was feeling really stressed and really bad and my back was hurting very much, etc., etc. and the doctor told me that, erm, what I needed to do was change jobs. And, erm, I was feeling very stressed at that moment and I ended up just ... just ... left me feeling really awful and disgusting so I just changed the practice. So, when I go to the doctors, regardless of what is happening to me, I just want them to understand, or at least to listen and to ...and to..to do as if they understand that I'm ill sort of thing. And if I'm not, probably try to convince me, but with arguments, not just saying "leave work" or whatever you have to do, but, erm ... but, yes, I guess ... I guess when I go to the doctors, I expect for them to listen and to give me something that will cure me really. I guess that's what doctors are for! *(little laugh)*

The prescription of antibiotics was contested in this patient's consultation, and this had an important link with doctor and patient 'face' which I analyse in chapter 6. The doctor in the example below talks about how prescribing antibiotics is linked with face as a 'good doctor':

Interview Dr 1 lines 211 to 223

Dr 1 [...] one thing which is very interesting, em, Turkish people seem to be very demanding for antibiotics and Dr Y, who has now left, she tended to give people quite a lot of antibiotics, em. And I had a Turkish woman come to me once with very similar symptoms - just cough and colds - and she was fine and I wasn't worried at all that she had anything more serious than that. Then she said on the way out, she said "Ah," she said, "You're very good, but I like Dr Y because she gives me the good medicine!" *(laughs)*

JB Yes, that's interesting.

Dr 1 And I thought that was very interesting, because her perception was that unless she got antibiotics it wasn't good medicine. But she was very nice about it, I think; I can't remember her very well, but I remember her very clearly saying "Ah, Dr Y gives me the good medicine," implying that my medicine wasn't quite as good! *(laughs)* But ... that's just her perception of things really. Yes.

JB Do you think there's quite a need to be a good doctor in patients' eyes?

Dr 1 Yes, I think definitely. I think you want to make your patients happy and you want people to like you. I mean I don't think there's anybody who doesn't want their patients to like you, but then it's hard to justify them liking you and giving them the wrong treatment, giving them not necessarily the best treatment and the best advice, even if it means they might not be quite as happy. But it depends what your priorities are, if you're desperate for everyone to love you, *(laughs)* then you might give them every single thing they want, if there's any way of justifying it. But I find that more difficult. I mean I do want patients to like me of course, but I wouldn't go to the extent of giving them a medicine to make them happy when it wasn't what I thought would be the best treatment.

JB Yes, yes.

Dr 1 So I hope I give good medicine! *(laughs)*

A 'good doctor' is therefore one who can prescribe good medicine, and get the patient better quickly. However, this creates a dilemma for doctors, because perceived pressure from patients to prescribe inappropriately calls into question a doctor's professionalism, and therefore threatens a doctor's face as a 'good doctor'.

Interview Dr 1, lines 59-73

JB Uh huh. Yes. So if you do land up prescribing, how does that make you feel?

LC Em. I suppose it depends on other factors as well. I mean certainly, if you're incredibly pushed for time, it would be easier to give someone a prescription, although that's something I rarely do, just to get them out of the room. It makes you feel like *(pause)* I suppose a bit like a pizza delivery boy, really, you know, they just want something and they ring up and get it, and that's fine if it's appropriate, but if it's not you feel that you've given them (a) a medication that's inappropriate, you've increased the amount of antibiotic prescribing which then will probably increase resistance. Em. It's, you know, it's the sort of thing that just makes you feel that you've done something that's a bit silly really, but has made the patient happy, so that's good. But they're not here to be happy necessarily.

JB Uh huh. That's a really interesting term "pizza delivery boy" - can you say a bit more about that?

LC Em. You know, I mean ... you know, you kind of expect people to come in and consult you as a professional person and for them to trust your abilities and your knowledge, and the training that you've done in order to make appropriate decisions and I know that doctors won't do that 100% of the time, but that's the assumption. But a lot of people, if they just want antibiotics are not coming with that frame of mind, they're not coming to consult and to see what you make of their symptoms and what your advice will be; they know that that's what they want. And then you think, well, actually if that's all it is you could then go off and get it on the internet or something like that, because they really don't want your judgements - they've by-passed that in their brain already, they've kind of by-passed well it's a doctor trying to look after me and give me advice, they've kind of gone past that stage and have gone to "I want to get my Amoxicillin." So ...

JB That sounds like it's a difficult thing to negotiate.

LC It is, I think it is. Because you're … because they're sort of treating you as a mechanism, as a means to an end, one particular thing, which is not always appropriate and that's quite hard.

JB Yes. Does that make you feel cross, or anything else?

LC It doesn't make me feel cross, it makes me *(pause)* … I don't know how it makes me feel. I don't get angry with people when they say that, I just think if that's what you want, and that's all that will make you happy, then fine! But, I just feel I haven't … I haven't really done a very good job, because my hands are tied really. Em. Yes.

GRIN Cartoon 4

Summary: discursive and ethnographic context

A 'patient perspective' is largely left out of this overview of discursive context: this reflects the asymmetry of representation in URTI-related documents (policy documents, guidelines, leaflets etc), and reflects the dominance of medical discourse in consultation.

Interaction between doctors and patients is shaped by its institutional setting (see chapter 2) and this chapter gives a sense of the institutional tasks and events in consultation, for example topics discussed, the nature and sequence of tasks, and the use of tools and technologies (Drew & Heritage 1998b; Fisher & Dundas Todd 1986; Sarangi & Roberts 1999). Doctor-patient interaction is also shaped by discursive ideas: discourses in medical texts and in my interviews show that URTI illness has a morally ambiguous status and that URTI consultations tend to be viewed negatively (by doctors).

Identity as a proper doctor may be threatened in URTI consultations since treating minor illness can be seen as work not worthy of doctors' status and training (Erickson 1999) (see chapter 1). 'Good doctors' are constructed in medical discourse as skilful (offering good advice and good medicine), caring (exploring patients' concerns), professional (not expressing negative emotion) and rational (not prescribing antibiotics). Doctors face dilemmas in that expressing negative sentiment about URTI consultation conflicts with being professional; trying to reduce workload conflicts with being 'patient-centred'; and reducing antibiotic prescribing may disappoint patients' expectations. Avoiding prescribing medication (cold remedies as well as antibiotics) denies both patient and doctor a transaction which has rich symbolism for 'patient-hood' and 'doctor-hood', and this has implications for interaction in consultation. On the other hand, feeling pressurised into treatments that they are uncomfortable with is associated with loss of face: doctors giving 'good medicine' risk also being 'the pizza delivery boy'.

Patients are also constructed by discursive ideas. 'Good patients' (in doctors' eyes) are those who consult only for legitimate reasons (significant psycho-social concerns or serious physical illness). Good patients should also have made efforts to self-care and/or waited a reasonable length of time before consulting, and respond rationally to education. Patients have a delicate task to do in establishing an identity as a legitimate patient: they tread a fine line between being seen as over-concerned and too quick to consult, and leaving things too late (Halkowski 2006). They need to convey a sense of

the seriousness or importance of their symptoms in order to justify a visit to the doctor but on the other hand, overplaying the seriousness of minor symptoms leaves patients open to being judged as hypochondriacs or of using the service inappropriately, with consequent loss of face. Patients are expected to make sensible judgements in deciding when consultation is warranted, but then to defer to the doctor's judgement in consultation (Bloor & Horobin 1975).

These discursive themes form a backdrop for doctor-patient interaction in URTI consultation. Both doctors and patients are 'positioned' by these discourses (Davies & Harre 2001), meaning that stepping outside morally sanctioned legitimate behaviour is accountable (Goffman 1959). Discursive context influences interactions between individuals. However, interaction also renews or contests discursive context (Foucault 1973; van Dijk 2001). For example, concepts of legitimacy change over time (Cardol et al. 2005): there is a two-way interaction between frames of reference in individual interaction and discourses in wider society. My literature review and interview data suggest that concepts of legitimacy (for both doctors and patients) are slippery, and this suggests that legitimacy is open for negotiation in interaction.

I therefore suggest that it is likely that the 'minor' status of URTI, the legitimacy of consulting, and choice of treatment will be salient in all URTI consultation talk, even if not explicitly referred to. I also suggest that these issues are linked with identity for both doctors and patients, and that doctors' and patients' interests are likely to conflict (for example, prescribing antibiotics may legitimise the patient, but discredit the doctor). Since these issues are morally accountable and emotive, participants are likely to pre-empt such threats to face (see chapter 2).

In the next chapter (5), I look at coughing as a resource that patients draw upon to assert their legitimacy as patients. I shall analyse patient and doctor identity in chapter 6, exploring the way that discursive ideas (for example the 'minor' status of URTI, the legitimacy of consulting and antibiotic prescribing) are related to maintenance of 'face' and both patient and doctor identity.

Chapter 5 - Could coughing have a communicative function?

In this chapter, I draw upon conversation analysis to explore whether coughing could have an interactional significance in communication between doctors and patients, exploring the significance of coughing in turn-by-turn interaction, but also for construction of patient identity.

Background

Whilst transcribing the video-taped consultation data I noticed that patients frequently coughed during consultations. It is known that paralinguistic features of interaction[25] such as pauses, breaths, laughs or crying can have communicative significance (I shall discuss some examples below). I wondered therefore whether patients' coughing was simply occurring randomly (perhaps unsurprising in a population complaining of respiratory illness) or whether coughing could also have a communicative significance.

Paralinguistic features of talk

Research on communication in medical consultations focuses mainly on verbal content of interaction since this is the most easily noted and analysed (see for example Bower et al. 2001; Kurtz et al. 1998). Much less researched are other dimensions of interaction such as the way something is said in terms of intonation and emphasis (Roberts 2000c) or body movements such as body orientation, gestures, gaze and facial expression, which all contribute to the way an utterance is interpreted (Heath 1986). The patterns and rhythms of talk, and the placement of non-lexical sounds and silence relative to words also contribute to meaning (Erickson & Schultz 1982; Potter & Hepburn 2005) as the following examples of paralinguistic features show[26].

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[25] Paralinguistic features of interaction are non-lexical components of communication including intonation, hesitation, noises, gesture and facial expression

[26] Like words, paralinguistic features do not have universal meanings, but need to be interpreted in context

Pauses/silence

Pauses or silence in talk may have many different interactional functions (Jaworski 1992). For example, turns at talk are usually skilfully co-ordinated without a great deal of overlap or long gaps (Sacks 1992): pauses signify the end of one speaker's turn, and the expectation of a reply. Pauses and hesitation also tend to characterise sensitive topics (Silverman 2001b) and difficult, 'dis-preferred' negotiations such as refusals tend to be marked with pauses (Sacks 1992). In the example below, an acceptance is 'interactionally preferred', and there is no delay in giving the reply to an invitation (examples are taken from Kitzinger and Frith 2001):

A. why don't you come up and see me [sometime
B. [I would love to

In the next example, the invitation refusal is marked by an initial delay, the preface 'well', a palliation ('it would be great') and an explanation. A delay in answering *can* be understood as a refusal without anything actually being said at all (Kitzinger & Frith 2001).

A. we were wondering if you wanted to come over Saturday, f'r dinner
B. (0.4) Well (.) .hh it'd be great but we promised Carol already

Laughter

To give another example of a paralinguistic feature of interaction, the placement of laughter may have communicative significance. For example in data where jokes were told, it appears that laughter 'bubbles up' spontaneously. However, on closer analysis, Jefferson noticed that laughter was placed within obscene words in a joke-telling sequence (Jefferson 1985).

A. And he came home and decided he was gonna play with iz o:rchids
B. With iz <u>what</u> ?
[..]
C. heh heh .hh PLAYN (h) W(h)IZ O(H)R'N

The placement of laughter seems to be no accident in this example, but serves the function of allowing people to talk in ways which are normally taboo.

These paralinguistic features have powerful communicative roles, in the example above, co-ordinating talk and managing delicate situations in a way which acknowledges social norms and expectations. Ethnomethodology and conversation analysis have shown that ordinary talk is not an accidental disorderly mess, but that the selection and placement of words, silence, paralinguistic features and body movement

convey meaning (see chapter 2 and below). I therefore wondered whether coughing might function interactionally in similar ways to these other paralinguistic features, as a form of non-verbal communication.

The question of whether coughing might have a communicative function arose from the close observation of data which is entailed in detailed transcription. I did not have a pre-existing hypothesis that coughing might have a communicative function, but this analytic question emerged (Murphy et al. 1998) from initially noticing coughing in one consultation characterised by open conflict over antibiotic prescription, and then noticing frequent coughing in other consultations as well.

Method

Data

This analysis draws on the data set of 33 video-recorded consultations which represent 'naturally occurring talk' (see chapters 2 and 3). Recordings of naturally occurring talk are preferred for conversation analysis (CA) since whilst interaction is skilfully negotiated moment by moment, these orderly patterns of interaction are not usually conscious (Heritage 2001). It is unlikely that people will recall when they coughed, and people are unlikely to be consciously aware of the complex interaction of linguistic and paralinguistic features of communication (Jefferson 1985; ten Have 1999). Video recordings allow repeated examination of events and also provide a record of bodily conduct which I used to help to interpret events (for example, noting whether direction of gaze changes following a cough and how gesture is used to animate descriptions of symptoms) (video data collection and analysis were discussed in chapter 3).

'A consultation' was counted as the time a patient entered the consulting room to the time that they left the room, so this captured face-to-face talk in the consulting room, but not talk (or coughing) which occurred outside the consulting room. It was difficult to decide what counted as one cough episode, since each occasion could include several individual coughs and/or throat clearing. This means that the graphical representation of data in this chapter is imprecise. However my analysis is mainly qualitative and I considered each cough episode regardless of its length, position or nature. Cough clips included a few turns of talk before and after each cough, selected to indicate the context in which each coughing episode occurred. This selection therefore involves judgement about what is happening in interaction. Although cough clips are presented as discrete examples, they were analysed in the wider context of the ongoing consultation rather than as isolated excerpts.

Transcription

Initial transcription of video-taped consultations

I transcribed the verbal content of all consultations, noting paralinguistic features (laughs, sniffs, prominent inhalations and exhalations, coughs, pauses, crying) and some features of bodily conduct (see chapter 3). Appendix 7 shows the transcription conventions, derived from Jefferson's notation (Jefferson 1985).

I developed a notation system to represent coughing in transcription, since it seemed that a quiet clearing of the throat might have a different significance to a loud prolonged cough for instance. It is difficult to establish a dividing line between a cough and a clearing of the throat, so I considered both to be instances of coughing.

k; KK; <u>KK</u>	increasing volume of cough
km	throat clearing sound
KKhh	wheezy cough

Transcription represents a simplification and interpretation of audible sound (Green et al. 1997) and this transcription system is a crude approximation of the actual sounds. I linked clips of the video consultation data to the written transcripts using Atlas.ti software, and this allowed easy replaying of the cough clips to remain in touch with the audible and visual consultation data. The written transcript allowed careful analysis of the complex interaction of words and non-verbal events. The example below shows the initial level of transcription I chose for the whole of each video-taped consultation:

Consultation Dr 1 and Pt B, lines 94-106

Pt B: no problem there .. but as I'm talking to you .hhh I feel like I want to cough like

Dr 1: mm

Pt B: KKh . KKh

Dr 1: quite phlegmy .. and are you a smoker ?

Pt B: yes doctor . I knew .. I knew you were going to (??) (laughing)

Dr 1: ?? how much do you smoke

Transcription of 'cough clips'

I selected every instance of coughing and transcribed these in greater detail (70 'cough clips'). This detailed transcription included features of the way in which things were said such as overlaps in talk and pauses, prosodic features such as emphasis, volume, and elongation of sounds, since these are important features of intended meaning of utterances (Roberts 2000b; Roberts 2000c). The example below shows the same clip with overlaps and emphasis included, and features of bodily conduct which appeared relevant to the data interpretation. I analyse this example of coughing later in this chapter (page 158).

Consultation Dr 1 and Pt B, lines 94-106

Pt B: no problem there .. but as I'm talking to you .hhh I feel like I want to cough like (gesturing with fingers around throat)

Dr 1: mm

Pt B: KKh . [KKh

Dr 1: [quite phlegmy .. and are you a smoker ?

Pt B: yes doctor (looking down to right) . I knew

Pt B: .. I knew you were going to [(??) (laughing)

Dr 1: [?? how much do you smoke (smiling)

Data analysis

Conversation analysis

Conversation analysis (CA) focuses on interaction between individuals, seeking to describe the competencies that ordinary speakers use (ten Have 1986). CA analyses patterns of interaction and communicative practices, asking 'what has happened' in a social interaction, 'how has this happened' and 'what has been achieved interactively' with a particular utterance (Drew et al. 2001; Sacks 1992) (see also chapter 2). Concepts and approaches in CA derive from Garfinkel's ethnomethodology, which is concerned with the investigation of everyday rationality, language and unremarkable events (Garfinkel 1967; Titscher et al. 2000). Ethnomethodology studies the methods used by members of a group for maintaining a sense of order and intelligibility in social life (ten Have 2002). Conversation analysis focuses on verbal interaction, but also includes analysis of non-verbal elements, so it is suited for addressing questions about the significance of coughing.

CA depends upon careful observation and analysis of data with a 'conversation analytic mentality' based on a particular way of understanding communicative processes rather than through application of analytic rules (ten Have 1999). There are several principles (deriving from ethnomethodology) which guide approaches to analysis.

- *The systematic organisation of talk*

Participants in talk co-operate to produce a skilfully co-ordinated flow of utterances. Talk is organised and orderly, and participants draw upon shared assumptions to make sense of each other (Garfinkel 1967). For example, talk is organised in turns, with intonation and pauses indicating the end of a turn. Shared expectations and assumptions allow talk to proceed smoothly, for example, the expectation that an answer should follow a question (Sacks et al. 1974). There are procedures for dealing with disruption to the expected order in interaction, for example, repeating a question if an answer is not forthcoming. Conversation analysis reveals the rules and assumptions which underlie the social organisation of talk.

- *Continuous and co-operative meaning-making*

As I have discussed in chapter 2, Garfinkel observed that people negotiate understandings continuously and co-operatively (Titscher et al. 2000). Meanings are created through people's interactions with each other, in other words constantly produced locally and negotiated between participants. The meaning of utterances depends upon the context in which they occur, and meaning is jointly produced. Utterances are produced and interpreted in the context of previous utterances and events, simultaneously contributing to the context of the next utterance (Titscher et al. 2000). Participants signal their understandings in their responses (as in the example just given) and CA takes advantage of this to look in the data to try to identify the meaning of events to participants (Heath 1998).

- *Patterns in Talk*

Ethnomethodology and conversation analysis see each particular situation as uniquely and locally accomplished by participants (Garfinkel 1967; ten Have 2002). At the same time, actions are designed to be recognisable as, for example, a greeting, a complaint, etc, so whilst social life is constituted moment-by-moment, it is at the same time a routine accomplishment (ten Have 2002). Recognisable patterns represent shared social knowledge which is essential for maintaining a sense of order and intelligibility. If patterns deviate from expected, this becomes 'accountable', for example the failure to

respond to a question, and this feature of talk helps to reveal participants' assumptions and expectations (Sacks & Jefferson 1992).

Paralinguistic features are harder to analyse than verbal features since they do not have the orderly structure of talk (Heath 1998), and there are fewer commonly agreed meanings for paralinguistic features than words, even within one particular culture. For example, blinking is physiologically necessary. However, eye movements are also an important component of communication. The direction of gaze signifies a speaker's intended audience (Goffman 1981) and eye contact signals attentiveness (in Western cultures) (Caris-Verhallen et al. 1999). The movement of an eye muscle may therefore be a reflex physiological movement, unconscious and un-noted by others (a blink). The exact same muscle movement may also be a wink, using a socially established code to intentionally signify a particular message to someone else (Geertz 1973). The key to appreciating the difference between these possibilities is in understanding their significance for the participants in a particular interaction. CA analyses participants' responses to preceding utterances for an indication of recipients' understandings (see page 49).

Similarly to blinking, it is unlikely that cough has a universal 'meaning' (especially when it is also a physical symptom). However the placement of cough may be patterned in particular ways in a consultation, and/or in particular utterances. This analysis looks to preceding and subsequent turns after an event (the cough) to see whether it was taken by participants as significant.

Analysis of cough clips

I used codes within Atlas.ti software to label each cough clip (see chapter 3 for discussion of data analysis). I linked each cough clip transcript to the video clip of the same extract using a hyperlink function within Atlas.ti which allows easy access to the 'original' video data. I wrote analytic notes using the memo function on Atlas.ti, which links free text comment to particular clips. Atlas.ti allowed easy retrieval of single clips or groups of clips from particular patients or particular parts of the consultation.

I coded consultations in terms of phases (opening; description of symptoms; examination or test; diagnosis, treatment or advice; and closing) since interactional tasks differ in different phases (Byrne & Long 1976; ten Have 2002) and I thought that coughing may have different functions in these different contexts. I looked to see whether coughing fell between phases, or was clustered in particular phases of consultations. Each micro-level cough clip analysis (just a few turns of talk) was linked

to awareness of communicative practices, tasks and events in consultations as a whole. I then looked for patterns across all of the video-taped consultations.

Following a preliminary (quantitative) analysis of patterns of coughing, I focused on the following questions:

Does patients' coughing play a role in interaction between doctors and patients?

- *How is coughing distributed throughout a consultation?*
- *How is coughing placed in relation to speech turns?*
- *What exactly has happened interactionally in each instance of coughing?*
- *How has this happened?*
- *What function could coughing have in sequences of talk?*
- *Can patterns be discerned across several consultations?*

I gave 'deviant' cases special consideration (Miles & Huberman 1994) especially patients who described having a cough but who did not cough in consultation, and conversely, those who said they did not have a cough who nevertheless did cough in consultation. I discussed my interpretations of data with researchers with backgrounds in sociology, anthropology, psychology, socio-linguistics and general practice.

I analysed all of the cough clips and have presented a selection from the total collection of 70 clips, choosing examples from different patients and doctors, and from different parts of the consultation.

'Findings'

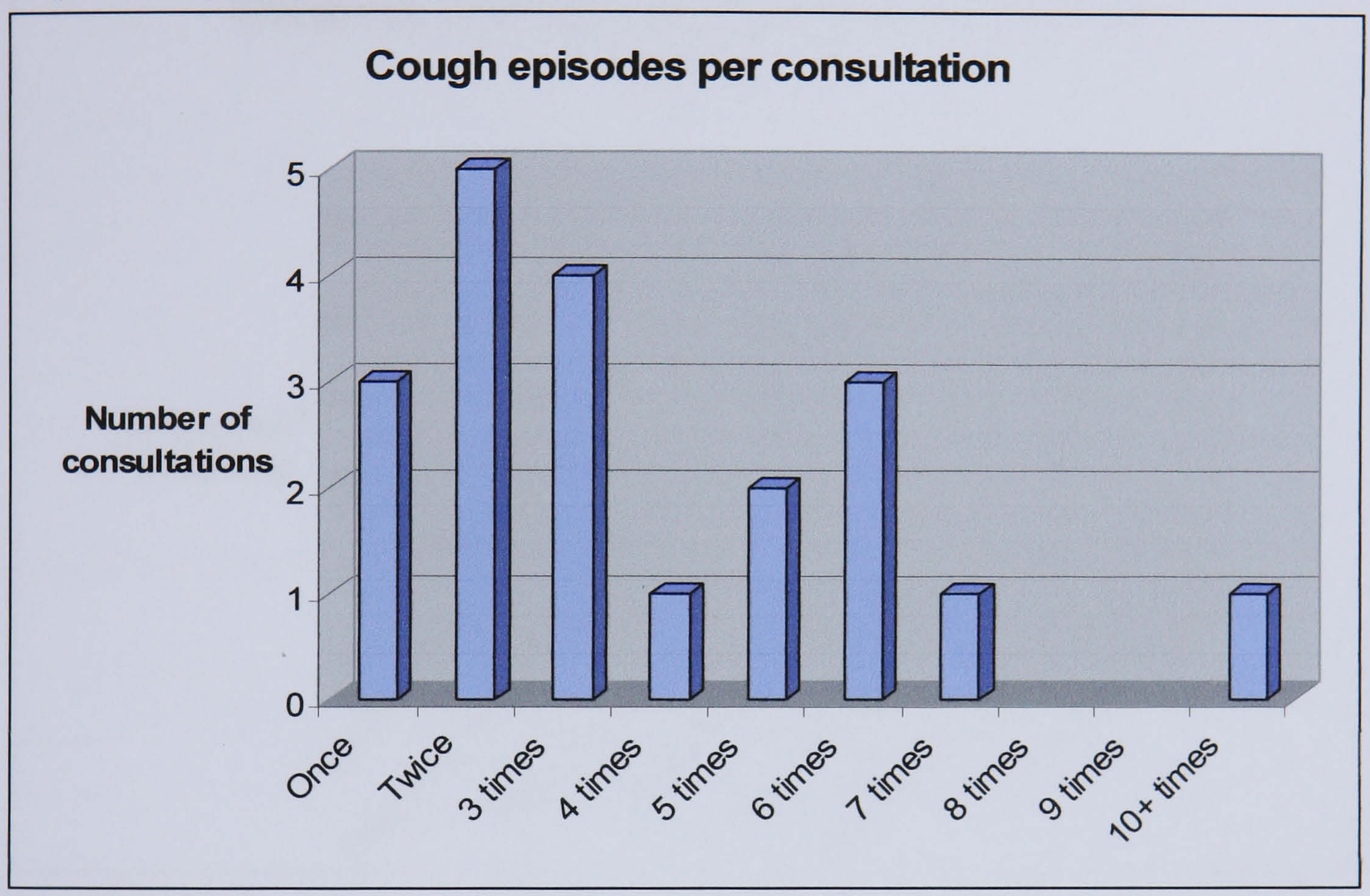
Coughing and relationship to symptoms

24 of the 33 video recorded patients were complaining of respiratory symptoms which had lasted less than 2 weeks (i.e. URTI symptoms like cough, running nose or sore throat). Another nine patients complained of URTI symptoms, but also had other symptoms such as coughing up blood, or more long-standing conditions such as asthma or chronic obstructive airways disease. In 27 of the 33 consultations, cough was one of the main troubles discussed. In most of these cases (18/27), patients coughed during the consultation, however a large proportion (9/27) did not cough in consultation despite raising cough as a problem or trouble. Of particular interest were the 2 consultations where patients coughed despite saying that they did not have cough symptoms.

	Cough mentioned as a trouble	*Cough not mentioned as a trouble*
Coughed in consultation	*18*	*2*
No cough in consultation	*9*	*4*
Total patients		***33***

Three patients coughed on only one occasion in consultation, but most patients coughed on several occasions (see graph below) allowing comparison of coughing in different locations within as well as across consultations.

Graph 5. Frequency of coughing in consultations



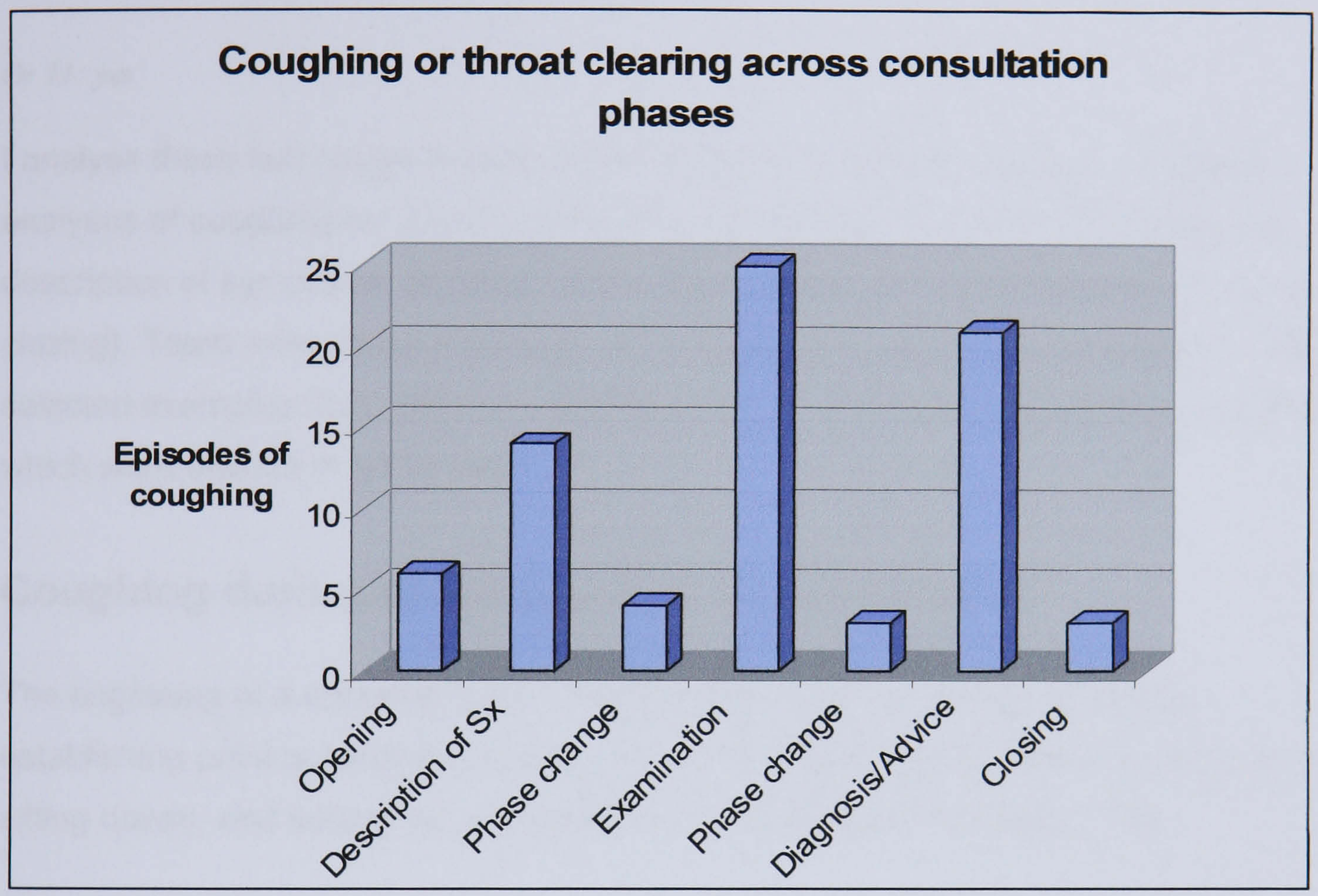
Patients coughed very much more frequently than doctors. Three of the doctors cleared their throats during consultations and none of the doctors coughed.

Placement of cough in consultation

The expected phases of interaction were present in all of the consultations (opening, description of symptoms, examination or test, diagnosis, treatment and advice, and closing) but were often overlapping (e.g. complaint and examination phases overlapping as questioning continued during physical examination) and did not necessarily occur in the order given above. Diagnoses were often vague, and interwoven with discussion of treatment and advice, so these phases were considered together. Phases were roughly sequential, but with frequent returns to previous phases.

The following graph gives an overview of where coughing fell in consultation, although it should be interpreted with caution because the consultation phases were not of equal length, and an 'episode' of coughing was difficult to define: this could mean a single cough, or a run of a few together. Coughing was distributed throughout consultation phases, but occurred most often in the examination and diagnosis/advice phases. Very few coughs occurred between consultation phases (see graph below).

Graph 6. Frequency of coughing in different phases of consultation



(Sx = symptoms)

Coughing rarely completely interrupted the speech of either doctor or patient, suggesting that fits of coughing are controllable. Coughs usually occupy a whole turn (example a), or a position within a turn, often at the beginning (example b). This arrangement/organisation tends to suggest that talk is co-ordinated with coughs, rather than coughing simply bursting through randomly.

Example a: occupying a whole turn of talk

Consultation Dr 11 and Pt S, lines 187-191

Dr 11: yes (1.0) okay (..) and how have you tried to treat it at home ?

Pt S: k (.) km

Dr 11: have you done anything to try to settle it down ?

Example b: within a turn

Consultation Dr 11 and Pt S, lines 65-69

Dr 11: and are there any other things

EL: ehh

Dr 11: at home which (..) are especially difficult ?

Pt S: k (.) K (..) I've got em (.) I've got a:: cough

Dr 11: yes

I analyse these two cough clips on page 159. In the following sections, I present analyses of coughing co-incident with particular activities in consultation (opening, description of symptoms, physical examination, diagnosis, treatment and advice, and closing). There were many examples of particular phenomena to choose from; I have selected examples from different consultations, and present all instances of cough clips which were deviant in some way.

Coughing during opening phase of consultation

The beginning of a consultation is occupied with greetings, checking names, establishing privacy (closing surgery doors) and an appropriate spatial location (e.g. sitting down), and sorting out equipment and documentation (Heath 1986).

A cough from the patient may be the very first event in consultation:

Example 1:

3 Pt R: Kk (sniff) (..) (sound of door closing, Dr sitting down)

5 Dr 12: hi I'm XX one of the the many- (looking at computer)

6 Pt R: yes (??) (sitting down)

7 Dr 12: many doctors here now these days

9 Pt R: (laugh, sitting down) (sniff) kk

10 Dr 12: (gaze on patient) what can I do for you today

12 Pt R: right em . got . quite painful glands

14 Dr 12: mm hm

16 Pt R: all round there I've got an ear infection (..) that could be connected I suppose and I've got also pain in my sinuses

This patient coughs and sniffs as he walks into the consulting room, before anything is said. The doctor greets the patient, introduces herself and makes a joke to which the patient responds with a laugh, a sniff and a second cough. The troubles described by this patient did not include cough. This was unusual, since most people who coughed in consultation also discussed cough as one of the symptoms troubling them (see page 149).

The patient's first cough occurs while the doctor is moving across the room whilst the doctor's gaze is towards the desk and away from the patient who is off-screen and closing the door. This cough occurs before any talking.

The second cough at line 9 occurs after the doctor's introduction and joke. The joke seems to cause some interactive difficulty for the patient; he does not reply, but instead laughs, sniffs and coughs where a turn at talk would be expected (Sacks 1992). In this data set, patients did not always need a direct invitation to recount troubles, but did wait until eye contact was established. Like the first cough, the second occurs before eye contact: the patient is seated with his body orientated towards the doctor but with his gaze averted. Such a combination of body orientation and gaze displays 'recipiency' (readiness to interact), in this example waiting while the doctor looks at the computer (Greatbatch et al. 1995; Heath 1986). The patient starts the account of his troubles as eye contact is made, and in response to the doctor's next utterance, 'what can I do for you?' (line 10). The second cough seems to indicate an awkward moment, and also signals a readiness to start the real interactive business of the consultation.

Both coughs in this example seem to have the role of preparing for the speech activities ahead, firstly of initiating the interaction, and secondly of giving an account of problems (Heritage & Robinson 2006). There is a tacit understanding about institutional tasks (Drew & Heritage 1998a): for example there is no comment about the doctor turning her attention to the computer, and there is no talk until she has finished. The patient's non-verbal conduct (bodily conduct and coughing) acts to signal his readiness to begin talking in a subtle way which does not need acknowledgement by the doctor, and does not therefore divert her attention from her computer-related task.

It seems odd that neither the patient nor the doctor raised coughing as a symptom in consultation, since patient R coughed several times throughout the consultation (in the

description of symptoms phase, during examination, and doctor's advice). The coughs seemed similar in interactional function to examples in other consultations, but were not made topics of talk. I speculate that there might be two reasons for this: firstly, this patient was a smoker and smoking *did* become a topic of talk. Coughing may have been seen by both the patient and doctor as 'normal' for smokers. Secondly, in addition to a sore throat, this patient had symptoms which are more medically legitimate than simple cough and cold symptoms: he had ongoing otitis externa/ear inflammation (given additional legitimacy by being a hospital diagnosis) and probable sinusitis with a bloody nasal discharge. The doctor prescribed antibiotics without much hesitation. In contrast to coughs in other consultations, perhaps in this consultation cough was not 'needed' as a symptom to help establish legitimacy (see later analyses for discussion of this).

A cough is also the very first event in the second example:

Example 2:

5 Pt T: kk (entering room, sitting down)

7 Dr 8: hi there

8 Pt T: hello doctor he he he

9 Dr 8: how are you ?

11 Pt T: oh well:: not so good

13 Dr 8: [okay

15 Pt T: [erm

17 Dr 8: (moving to close door)

19 Pt T: kkmm (doctor sitting down. ..) I had the flu (..) and er (..) it left me with a cough in the night (.) a little cough (??) could just feel it tingling and I cough quite a lot in the night sometimes wet myself you know ?

There are striking similarities between examples 1 and 2: both patients cough as they enter the room and again before beginning accounts of their troubles. The direction of gaze in both examples is similar: the first cough takes place whilst both doctor and patient are moving across the room, and the second occurs just before eye contact is made and troubles are recounted.

In this example the patient is ready to start the account of her troubles at line 15, and begins with 'erm', a preface which claims the floor (Sacks & Jefferson 1992). However the doctor is not yet ready to listen since he is involved with closing the door and moving across the room. The second cough acts to signal a readiness to continue her turn, and she waits until the doctor sits down and makes eye contact before doing so. This cough also forms part of this patient's account of her troubles – the quiet cough she gives in line 19 ('kkmm') is consistent with her verbal description of the little cough that she has. I discuss this 'echo' effect further on page 162 (the correspondence of the verbal description of the cough with the characteristics of coughs in consultation).

In the next two examples, a cough is again the first utterance from the patient, following the doctor's greeting:

Example 3:

3 [out of frame] Dr 1: Pt E ? ..hello, come through (4.9) hello there (..) have a seat (..) hello

5 Pt E: (2.3 patient sitting) khh .. khh

7 Dr 1: I'm doctor 1 (sitting down) we (..) we haven't seen you here before

8 A (aunt) [out of the frame] no

10 Pt E: yeah

12 Dr 1: ri:ght (..) how can I help today ?

14 Pt E: aaah I'm asthmatic

16 A: yeah what (...) asthma attack (...) tonight

In example 3, the cough appears instead of a verbal turn: at line 5 either a returned greeting or a 'thank you' might be expected, but instead the patient coughs twice. This patient is accompanied by his aunt, and she does not say anything either. As with the other examples, the patient has sat down, and has an averted gaze while he coughs. Eye contact is established between doctor and patient during line 7 while the doctor says 'I'm doctor 1'. As in the previous example the placement of the cough and body positioning may signal readiness to start the business of the consultation. In this example it may also have another function: here there are three people present, and the cough helps to demonstrate which of the three is the patient.

Example 4:

[Husband off screen and quite difficult to understand]

05 Dr 16: Hello .. Pt B .. come through sorry to keep you waiting .. (door closing sound)

07 Hus: (???)

09 Pt BB: khh.. KKhh

11 Dr 16: hiya

13 Husband: (??) took so long today (???) (all sitting down)

15 Dr 16: sorry ?

17 Hus: been out there an hour

19 Dr 16: sorry

Here again, a cough occupies a position where a greeting or thank you might be expected, acting as the second part of an adjacency pair in serving to acknowledge the doctor's greeting. In this example there are again three in the interaction, and coughing helps to confirm which of the three is the patient. This surgery session was running very late (by about an hour), and the doctor offers a platitude 'sorry to keep you waiting' in line 5. A reply such as 'that's okay' might be expected, to preserve the usual politeness of social interaction (Goffman 1967). Instead, the patient coughs twice (line 9). Unlike the patient, the husband addresses the issue directly, commenting on the length of the wait in lines 13 and 17.

Summary - opening phase

The opening phase of consultation is about preparation for the main business of the meeting, and coughing seems to complement these preparatory tasks. In these examples, coughing is placed in the first few exchanges, functioning to acknowledge a doctor's greeting and indicate a readiness to begin talking. In situations where there is more than one person consulting, coughing helps to confirm who the patient is. Coughing is involved in the establishment of discourse and situated identities (see page 63): for example, cough indicates a 'recipient' discourse identity (i.e. waiting and ready to interact). This is linked with patient identity in that it is doctors who control the beginning of the main business of a consultation (with a question such as 'how can I help') (Gafaranga & Britten 2003). In these examples, cough also helps to build identity

as a patient through signalling which person has symptoms, and it also presages the nature of the clinical problem to come; that is, a respiratory problem. Coughing also seems associated with awkward interactional moments (the laughter in example 1, and pending complaint in example 4).

Description of symptoms phase of consultation

It is in this phase of the consultation that patients are given an opportunity to describe their troubles, and in which doctors question further to gather information about the patient's complaint as evidence in support of particular diagnoses (Silverman et al. 2005). Asking for an appointment implies a claim for medical attention, and this claim has to be accounted for, usually by describing symptoms, voicing complaints and/or asking the physician to examine parts of the body (Heritage & Robinson 2006; ten Have 2002).

These examples show how coughs can be involved in this phase of the consultation, both in describing symptoms, and also in strengthening claims for medical attention:

Example 5

82 Pt B: she did my heart (touching chest) she said that everything was perfect

84 Dr 1: OK (...) [alright

86 Pt B: [so (....)

88 Dr 1: are you eating and drinking OK ?

90 Pt B: yes yes I haven't you know (..) no

92 Dr 1: okay

94 Pt B: no problem there (..) but as I'm talking to you (.hhh) I feel like I want to cough like (.)

96 Dr 1: mm

98 Pt B: KKh . [KKh

100 Dr 1: [quite phlegmy (..) and are you a smoker ?

102 Pt B: yes doctor (looking down to right) (.) I knew

104 Pt B: I knew you were going to [(??) (laughing)

In this example, the patient describes his troubles as a terrible cold with sneezing, sore throat, aches and pains, and headache. His attendance in an emergency Saturday morning appointment has been a point of contention earlier in the consultation, and his indirect request for antibiotics has been ignored by the doctor. The symptoms mentioned so far have not been followed up with more questions, but the doctor

instead asks questions about symptoms which are largely absent (breathing trouble, heart trouble, difficulty with eating and drinking).

The patient describes the cough in a rather unusual way, as something experienced there and then in the consulting room (line 94). He describes the cough as involuntary (feeling he wants to cough whilst talking) but places the coughs in a 'turn' after the doctor's 'mm' (line 98). The coughs serve to demonstrate the bodily presence of the symptom the patient has just described. His cough is noted and commented upon by the doctor, and the demonstration serves to raise another symptom, phlegm. Patient B had earlier listed several symptoms, but cough is raised for the first time at line 94. The demonstrated cough results in a direct acknowledgement by the doctor whereas the previously mentioned symptoms were not acknowledged.

What might this cough achieve interactively? This patient's account of his symptoms is addressing two explicit agendas; firstly the contested legitimacy of consulting in an emergency appointment, and secondly his request for antibiotics. At the point in the consultation where the cough appears, the symptoms so far offered have not received the doctor's acknowledgement, and are not explicitly accepted as legitimate reasons for consulting or of sufficient concern to warrant antibiotics. The cough therefore introduces an additional medical concern, one that can demonstrate the patient's suffering there and then in a tangible way to the doctor. The format of this presentation of symptoms (over many turns of talk) suggests a search for a 'legitimate' symptom, and the cough is a candidate.

In a reversal of the pattern in the previous example, in the next example the patient coughs before her verbal description of cough symptoms:

Example 6

61 Dr 11: and are there any other things

63 Pt S: ehh

65 Dr 11: at home which (..) are especially difficult ?

67 Pt S: k K (..) I've got em (.) I've got a:: cough

69 Dr 11: yes

71 Pt S: a bad cough from about (...) well from about couple of months ago I didn't complain the last time I came but (..) I had it from that time k km coughing coughing (.) you know a dry cough

73 Dr 11: yes

The doctor and patient had previously spent some time discussing pains in the hands and feet. The doctor's questioning at lines 61 and 65 then uncovers a new problem, a cough. The patient's response at line 67 is marked by signs of interactive difficulty (Silverman 2001b): pauses, false starts ('I've got em') and a delay before actually saying 'cough'. The cough itself forms part of this perturbation, acting as a hesitation at the beginning of the utterance. The doctor's question relates to a 'patient-centred' agenda in which the social and psychological context of symptoms is explored (Campion et al. 2002). It seems that the patient does not understand this question, since she responds by giving a new symptom instead of with details about how her symptoms are affecting her. It can be difficult for patients to understand the context for doctors' questions (Fisher & Dundas Todd 1986) and this seems to have caused misunderstanding and interactional difficulty here.

The patient's account continues in line 71, addressing the legitimacy of her help-seeking by saying that it's 'a bad cough', and that she has had it for a while without seeking help.

In the same way as in the previous example (5), the audible cough demonstrates and enacts the patient's suffering. Patient S also uses a hand gesture, a repeated, forward motion of her left hand (see figure 9) to accompany her verbal description of the persistence of her cough.

Figure 9. Left hand gesture

Later in the consultation she continues her description, again audibly demonstrating the cough in a manner which echoes her description of the dry cough, and using gesture to animate her account:

Example 7

85 Dr 11: and tell me now about the cough you were describing

87 Pt S: k km yes it's like the dry (..) dry cough yes (..) kK and (...) sometimes I feel it just come up you know a dry (?) but I cant I have to cough cough cough until

89 Dr 11: yes

91 Pt S: bringing out phle:gm and you know

93 Dr 11: you bringing up phlegm

95 Pt S: phlegm yes

This patient's left hand moves up abruptly with her description of the cough coming up. A downward motion accompanies her description of attempts to keep the cough down (see figure 10). She describes an unsuccessful struggle to keep her symptoms under control, although the coughs in her talk seem placed in ways which do not disrupt the flow of talk (in other words, the cough seems controllable in consultation).

Figure 10. Left hand gesture

Similarly to example 5, this patient's account and her coughing help to portray her help-seeking as legitimate, in other words someone who has struggled for a while with her symptoms, and only sought advice when symptoms have persisted. Patients' troubles often cannot be directly witnessed (Heath 2002): hand gestures help to animate descriptions, and coughing in consultation presents physical evidence for the doctor to witness.

Later in the same consultation, the cough is discussed again:

Example 8

179 Dr 11: um (..) okay (..) and what did you think was causing the (..) cough that you've got

181 Pt S: (2.0) um (..) I don't know (..) I don't know (laughing) I don't know I just (..) (??) you know

183 Dr 11: yes

185 Pt S: e::r I don't know that anything (..) caused it

187 Dr 11: yes (1.0) okay (..) and how have you tried to treat it at home ?

189 Pt S: k km

191 Dr 11: have you done anything to try to settle it down?

193 Pt S: mm (shaking head) no (2.0) I just sometime- just drink wa- some water I you know

195 Dr 11: just drink water

The doctor is asking questions about the patient's health beliefs (what has caused the cough, what she has done to treat it so far). At line 187 he asks how she has tried to treat it at home, and the patient coughs in place of a verbal response (line 189). Absence of response to a question is 'accountable' (Sacks 1992): a response is pursued by the doctor by asking the question again in a different way (line 191. Similarly to example 6 (from the same consultation), the cough is associated with interactional 'trouble' (Sacks 1992). Patient S finally gives a response after a two second pause in line 193. The doctor's line of questioning (from line 179 to 191) seems to cause some measure of discomfort: the patient's responses are marked by pauses, laughter, 'um', 'er', and saying 'I don't know' several times and coughs. Perhaps giving a small cough supplies a response that indicates that the cough is simply 'there' rather than requiring explanation.

In this next example, the patient's verbal description of her cough evolves during the consultation, and the nature of the cough changes too.

Example 9

15 Pt T: [erm (..)

17 Dr 8: (moving to close door)

19 Pt T: kk mm (doctor sitting down. ..) I had the flu (..) and er (..) it left me with a cough in the night (.) a little cough (??) could just feel it tingling and I cough quite a lot in the night sometimes wet myself you know ?

21 Dr 8: oh dear

This patient coughs before she gives her account of her troubles (line 19) (noted in example 2 from the same consultation). She plays down the severity and effect of her cough, using the terms 'little', 'just' 'quite a lot' 'sometimes'. This kind of playing down of complaints can accompany descriptions of symptoms which risk being seen as trivial or minor (Heritage & Robinson 2006) (discussed further in chapter 6). The cough at line 19 is a little cough, in keeping with the description given.

Despite this understated beginning to her story, the patient later paints a picture of a cough which is causing considerable suffering and disruption. In lines 59 to 95 (not shown), patient T describes the cough as 'building up', 'welling up', occurring 'uncontrollably', and associated with phlegm. The troubles that she attributes to the cough include waking at night, fits of coughing, leg pain and wetting herself. This more dramatic portrayal of her symptoms is echoed with coughing fits which occur during physical examination. The cough is noted by the doctor at line 231.

229 [long silence during physical examination] kkK kkK .hhh KK KK

231 Dr 8: the cough

233 Pt T: ye:s (..) just feel tickly (8 sec)

235 Dr 8: can sit forward ? (8 sec)

237 Pt T: KKh KKh .hhh (..) KKK KKK (..) KK (sniff) (...) KK KKK .hhh KK KKm (..) .hhh hhh (5 sec silence)

239 Dr 8: okay

In the next example[27] (and like previous examples), coughing seems to accompany interactional difficulty:

Example 10

11 Dr 7: how can I help ?

13 Pt M: yeah I'm having (..) well (.) flu-like symptoms since last week Tuesday

15 Dr 7: okay

17 Pt M: so I took some time off work but (.) yesterday when I went back to work I didn't feel any better

19 Dr 7: right

21: got a (..) s:ore throat (...) I'm just aching (1.6) that's about it (laugh) kk kk kk

23 Dr 7: (laugh) okay (...) it's been going on a week now

25 Pt M: yes (..) mm hm

The patient's account of her symptoms starts at line 13. The doctor's acknowledgement tokens ('okay' and 'right') are with a rising pitch, indicating expectation of a continuing account. The patient ends her account at line 21, with a falling pitch on 'aching',

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[27] quoted in chapter 4

indicating that the utterance is complete. There is a pause of 1.6 seconds which is 'accountable', in other words something is expected in this space (Sacks 1992). What is expected seems to be more story, since the patient's response indicates that there is no more to add ('that's about it', line 21). A pause, a laugh and a cough accompany this interactionally difficult moment.

The doctor does not ask questions about the sore throat and aching, but continues on to questions about other symptoms. A second cough in line 79 again accompanies signs of interactive difficulty (pauses, laughter, mitigation ('not really')). This time the cough is explicitly acknowledged by the doctor, who continues with questions about phlegm. The cough provides demonstrable evidence of a symptom which is given acknowledgement and legitimacy through further questioning about phlegm (not shown). As suggested in chapter 4 and as in example 5 above, this structure of revealing symptoms over many turns of talk seems to suggest a mutual search for legitimate symptoms.

75 Dr 7: okay (..) and you were getting a bit better were you starting to eat a bit more or-

77 (?) over the [weekend

79 Pt M: [over the weekend (2.0) no (.) not really (laugh) not really .hhh KK KK

81 Dr 7: and have you got a cough ? (.) I hear a bit of a cough

83 Pt M: and a cough (.) yes

Summary - description of symptoms phase

Many symptoms are not visible at all, or only visible with special examination equipment: coughing is one of the ways that patients can demonstrate symptoms to doctors. It appears that cough is drawn upon by patients as a resource to demonstrate symptoms in a tangible, physical way. Coughing can enact symptoms, with coughs in consultation matching their verbal descriptions. I suggest in chapter 4 that the legitimacy of consulting is contested for URTI illness. In these examples, cough helps to justify a patient's request for medical attention and contributes to identity as a legitimate patient (discussed in chapter 6). Coughing seems to be a more legitimate symptom than other URTI symptoms: cough was the most frequently mentioned symptom in this data set (see page 127) and seemed to elicit further questions in a way in which other symptoms did not (see example 10). Again, coughing is also associated with interactive difficulty (misunderstanding or difficulty answering questions, examples 6 and 8).

Coughing during physical examination

Examination forms part of the core process of diagnostic evaluation by doctors (Khot & Polmear 2003). Communication may be difficult during physical examination because a patient may be physically unable to respond (e.g. in throat examination) and because doctors alone have access to information provided by medical instruments and expertise (Perakyla 1998). Coughing was frequent in the examination phase (see graph on page 151). The physical examination took some time for most of the patients in this data set (see chapter 4) and was marked by relative silence while doctors looked in throats, listened with stethoscopes etc. Most physical examinations took place off the video screen, although any dialogue remained audible. It is difficult to interpret coughing in the examination phase because verbal interaction was generally minimal and the interpretive clues usually present through analysis of bodily conduct were missing when examination was off-screen.

Cough as a physical sign

Doctors sometimes specifically asked patients to cough as part of their diagnostic assessment:

Example 11

This patient is treating the topic of her cough and phlegm as sensitive and difficult to address (Silverman 2001b). Her description of coughing up 'big greenies' is whispered:

05 Pt C: I've got a sore throat which I've had for about two weeks (..) and it's usually worse in the morning (.) and the evenings (..) and ∘it's causing me to cough up (..) em (..) big greenies (.) which I don't like (..) at all∘

Her reference a few lines later to coughing up infection is marked with prominent hesitation and the preface 'it sounds really awful':

21 Pt C: em (1.0) (tut) (1.0) sounds really awful (..) because (..) I coughed up (..) like obviously (..) er (.) infection (..)

The doctor's request to examine her is also associated with perturbation:

31 Dr 4: alright then let's have a look (..) at your throat ?

33 Pt C: if you really want to (laughs)

35 Dr 4: (laughs) em (..) km do you want to just (..) give me a cough no:w

37 Pt C: em (1.0) (laugh) ye<u>a</u>h (..) KK KKm

39 Dr 4: but there's green gunk coming up from your ch<u>e</u>st is there ? (preparing ear thermometer)

41 Pt C: em (..) I don't know wh<u>e</u>re it's coming from

Both the doctor's and the patient's utterances are turbulent in this extract (Silverman 2001b). The doctor pauses and clears her own throat before asking the patient to cough (line 35) and there are prominent pauses and laughter before the patient's cough (line 37). Sensitive topics may be marked with features such as pauses, laughter and other devices (Silverman 2001b). This patient's account portrays her symptoms as unpleasant and embarrassing ('big greenies which I don't like at all', line 5) and the verbal and non-verbal interaction also implies that the doctor's job is potentially unpleasant (lines 31-37).

Most talk about symptoms was not treated as sensitive or difficult in this data set, despite the fact that talk about bodily excretions is taboo in ordinary interaction (Lawler 1991). Instead, doctors and patients tacitly accepted discussion of taboo topics (phlegm, vomit etc) and ordinarily taboo behaviour (removal of clothing).

The doctor's question in line 39 seems to imply that the cough did not have the expected qualities, perhaps casting some doubt on the patient's previous account of coughing up 'big greenies'. The cough in this example is treated by the doctor as diagnostic evidence: she evaluates the qualities of the cough, treating it as a physical sign, and bodily indicator of disease (Khot & Polmear 2003).

Coughing during examination of the throat and chest

Doctors commonly asked patients to take deep breaths while they listened to the chest with a stethoscope, and in order to measure peak flow[28] and coughing often accompanied these events.

Here the patient is asked to take some breaths whilst the doctor is examining her chest. The examination is off-screen, but the doctor is presumably using a stethoscope.

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[28] A peak flow meter is used to measure the volume and velocity of forced out-breath, as an indicator of lung constriction in asthma.

Example 12

249 Dr 7: okay .. let's just have a listen to your chest (1.5) can I lift this up ?

251 Pt FF: yes (2.0) (?)

253 Dr 7: (2.6) take some breaths

255 Pt FF: .hhh hhh

257 Pt FF: .hhh KK (sniff) hhh

259 Pt FF: .hhh hhhh (breathing continues)

Coughs were sometimes accompanied by sniffing. Sniffs are similar to coughs in being physiological events which are controllable, and are also demonstrable signs of illness, so their placement in interaction is of analytic interest. The sniff takes the place of an in-breath in line 257. Neither the cough nor the sniff is commented upon either here or later in the consultation. In this example, there is no dialogue during the chest examination, and bodily conduct was not visible, so it is very difficult to assess whether the placement of cough or sniff has an interactive function. It is likely that the action of taking deep breaths would precipitate coughing.

In the next example, the patient is asked to breathe out hard into a peak flow meter:

Example 13

148 Dr 14 .hh and breathe in .hhh and then try and . breathe out as hard and fast as you can . just-

150 Pt FF: (??)

152 Dr 14: (?? idea)

154 Pt FF: .hhh HHHH (into peak flow meter)

156 Dr 14: that's right very good .. [technique (taking peak flow meter)

158 Pt FF: [KK KK

160 Pt FF: .hh KK KK (Dr looking at peak flow meter)

162 Dr 14: yes that's .. pretty okay mean it's (??) predicted it's five hundred . can I just have a listen to you (picking up stethoscope and standing up)

The patient's cough at line 158 occurs while the doctor is taking the peak flow meter from the patient and looking at the reading. The doctor then puts the meter away whilst talking in line 162. There is no eye contact until the doctor says 'can I just have a listen

to you' (line 162). The patient's coughing overlaps with the doctor's turn at line 156, but does not seem to have an effect on the sequence of events. The doctor's attention is principally on examination equipment at the time of coughing, and it is not evident from the verbal exchange whether the cough has been noted or not.

In the next example, taking a throat swab seems to precipitate patient's coughing:

Example 14

136 Pt A: aaah (mouth open)

138 Dr 3: (3.0 taking throat swab) ooh sorry that's (horrid doing that)

140 Pt A: k kk

142 Dr 3: coughing up any phlegm ?

144 Pt A: um (1.3) yes (..) specially because of the (...) especially at night (.) I seem to because of the snot

coming [down=

146 Dr 3: [right (??)

148 Pt A: =I just try and cough it up again

This patient had not so far mentioned a cough, but his cough at line 140 is noted by the doctor and leads to a new line of questioning about coughing up phlegm (as in previous examples). The doctor's response shows that she has taken the cough to be a physical sign of bodily disease, and her further questions reveal new symptoms, cough and phlegm.

Summary - examination phase

Coughing in the examination phase often seems precipitated by the physical activities involved in respiratory examination, for example deep breathing or touching the throat for a throat swab. Four people coughed only in the exam phase; the other ten all coughed in other phases as well. Cough may be noted by doctors as a physical sign, either in directly asking patients to demonstrate a cough, or in commenting on an incidental cough.

It was not possible to identify a specific function or interactional meaning for many of the examples of cough which occurred in the examination phase. This is partly a methodological problem, since it is difficult to interpret coughing which occurred off the video screen and/or during long verbal silences. Unless a comment is made about

coughing, it is impossible to know whether it has been noted by participants in interaction: most coughs were not remarked upon by either doctors or patients. It does seem likely that coughs which occur in association with physical events such as taking deep breaths or taking a throat swab represent reflex physical responses.

On the other hand, the examination phase is also the time when doctors gather evidence of bodily signs (Mangione-Smith et al. 2003). Coughing in the examination phase therefore also coincides with the time when the doctor's attention is focused on the patient's body, so a cough occurring during the exam phase may convey something of the corporeal experience of illness.

Coughing during discussion of diagnosis, advice or treatment

This is the time when a doctor announces conclusions, usually a diagnosis first, followed by a treatment proposal or advice. The doctor's conclusions are usually discussed, and require some kind of acceptance by the patient (ten Have 2002).

In the following example, the doctor has just finished a respiratory examination in a patient whose troubles include a 'wheezy kind of cough' (line 130, not shown).

Example 15

198 Dr 14: it sounds clear but it . it's possible [you are getting wheezy

200 Pt FF: [yes

204 Dr 14: [certain [times of the day [you know

206 Pt FF: KK [.. [KK [mm

208 Dr 14: have you ever used an inhaler at all in the past

The doctor has not found evidence of chest ailment during the physical examination (line 198). This is potentially face-threatening for the patient, since the 'clear chest' on physical examination contradicts the patient's account of a wheezy cough (see chapter 6). The doctor manages this potential problem by leaving open the possibility that wheeze might occur at other times of day (lines 198 and 204). The patient's two coughs come between 'yes' and 'mm' (lines 200 and 206), and in this sequence the patient seems to agree with the doctor's explanation for the absence of wheeze on examination. The cough here seems to form part of this 'agreeing' sequence, and also acts to display evidence of a physical symptom despite the doctor's pronouncement that the chest 'sounds clear' (line 198).

This next person describes a cough with phlegm and blood and is concerned that her symptoms are attributable to cancer. She expresses concern that cancer is unpredictable, comparing it to morning sickness which some women get and others don't. There are two children also in this consultation; child 1 shouts through most of the consultation, with a noticeable silence during this discussion about cancer.

Example 16

196 Dr 8: but what we do know is how common cancer is in women of your age and ... lung cancer is unheard of

198 Pt EE: ... mmmm

200 Child 1: BABY ! [child's talk then ends]

202 Dr 8: although we know that some women get . morning sickness and some don't so- (looking at computer)

204 Pt EE: .. yes .hh kk kmhh

206 Dr 8: er- em. (looking back to pt) so you become ... concerned that you might have cancer

208 Pt EE: (??)

210 Dr 8: mm .. because of these symptoms is it or

The doctor explains how unlikely cancer is in line 196; there is a pause before the patient responds at line 198; her 'mmm' is prolonged and sounds unsure. The doctor's attempted reassurance continues at line 202, and he then turns to the computer, which signals an end to this sequence. The patient pauses before responding, saying 'yes', breathing in and then coughing whilst the doctor is looking at the computer (line 204). At line 206 he stops looking at the computer, makes eye contact with the patient again and addresses her concern about cancer. What has happened here? This exchange could have ended at line 204 if the patient had accepted the doctor's reassurance (i.e. a 'no problem' diagnosis), but it is evident that this is not taken as adequate acceptance, despite the patient's 'yes'. The pause, tone of voice and cough contribute to keeping the topic open, and doctor and patient go on to negotiate an X-ray and blood tests to exclude cancer.

The following is another example of where the patient resists the doctor's formulation of the problem and treatment:

Example 17

This patient is one of the two who cough in consultation despite not raising cough as a problem (see example 1). In this example, the patient coughs only in the latter part of the consultation, during the diagnosis/treatment/advice phase and in the closing phase. The doctor has earlier said that he feels that antibiotics are unnecessary, and he goes on to advise about treatment:

131: Dr 9: (..) I would suggest (..) yes paracetamol or ibuprofen is a good (...) symptomatic treatment (..) um (.) and you'll be fine

133: Pt K: (looks down to right) fine (..) okay (looks at Dr) (.) well (..) (shrugs shoulders, laughs) thank you very much

135: Dr 9: (laugh) [anything else ?

137: Pt K: [I won't take antibiotics again [(.) no not at all

138 Dr 9: [(laugh)

139: Dr 9: no (.) I say there are times when they are useful but=

141: Pt K:= KK (.) km

143: Dr 9: but (..) not necessarily for (.) for this sort of thing

145: Pt K: okay (..) (??) yes (.) just waiting until it goes really

147: Dr 9: yes and a (.) 'nother day or so and=

149: Pt K: = KK (.) [km

151: Dr 9: [you'll be completely fine

153: Pt K: fine well thank you very much

155 Dr 9: alright ?

157 Pt K: (smile/laugh)

159 Dr 9: if you don't think it (.) if you think it's getting worse again then obviously let us know

161: Pt K: well (..) hopefully not (.) because I feel much better today (.) regardless whether it wasn't the antibiotics but [(..) (laugh) but I do feel much better

There seems to be an asymmetry between the verbal exchange and non-verbal events in this example. Studying the verbal interaction, the patient seems to be accepting the doctor's formulation of problem and treatment. For example, he says 'fine, okay, well,

thank you very much, I won't take antibiotics again' (lines 133 and137). However, there are signs of interactional 'trouble' in this response (Davidson 1984) since he hesitates, laughs, uses the preface 'well' and shrugs his shoulders before saying 'thank you very much' (line 133). The coughing occurs during the doctor's continued explanation about antibiotics (lines 139 and 143) and assurance that the patient will be fine (line 151). The coughs occur where backchannel responses such as 'mm', 'yes', or head nods might be expected (McClave 2000; Sacks & Jefferson 1992) but the coughs are prominent since they are loud in volume. The patient again says 'thank you very much' at line 153, and this could well lead to the end of the consultation. However the doctor does not take this as a satisfactory end-point, since he says 'alright?' at line 155, and this leads to a continued discussion of the nature of the illness.

As in the last example, the coughs are placed at the time that the doctor is articulating a 'no problem' diagnosis (Heritage & Stivers 1999), in other words formulating the patient's problem as not requiring treatment from the doctor. The placement of coughs seems to act as resistance to this 'no problem' formulation, and serves to keep open the dialogue about the nature of the illness. The coughing seems to convey that the patient is not ready to accept the doctor's advice, despite apparent verbal agreement. I analyse the whole of this patient's consultation in detail in chapter 6, exploring the interactive difficulty caused by a 'no problem' diagnosis.

Summary - diagnosis/treatment/advice phase

A large proportion of coughs came in the diagnosis/treatment/advice phase. This phase was characterised by a fair amount of interactional difficulty as doctors gave 'no-problem' diagnoses, explained that they held no magic treatments, and argued against prescribing antibiotics (see chapter 4). Coughing in this phase was associated with the interactional tasks of agreeing or disagreeing. Disagreement was rarely overt, but coughs were associated with perturbation phenomena and acted to keep discussions open (Gwyn 2003c), eliciting more explanation from doctors. As I discuss in chapter 6, it is difficult for patients to directly dispute doctors' diagnoses: coughing seems to act as a subtle resource to signal that issues are not resolved.

Coughing during closing phase

The closing phase is concerned with making arrangements and social leave-taking with well-wishes and thanks (ten Have 2002). Three of the 70 or so coughs were located in the closing phase, and all three were right at the end of consultations as the very last event in leave-taking.

To re-visit the previous example, example 17, this patient's coughing in the diagnosis/ advice/treatment phase was associated with difficulty in agreeing whether antibiotics are appropriate for the patient's illness. Below is the next exchange:

Example 17 (continued)

159: Dr 9: if you don't think it (.) if you think it's getting worse again then obviously let us know

161: Pt K: well (..) hopefully not (.) because I feel much better today (.) regardless whether it wasn't the antibiotics but [(..) (laugh) but I do feel much better

163: Dr 9: [(laugh)

165: Dr 9: good

167: Pt K: right (.) thank you very much (standing up)

169: Dr 9: that's fine

171: Pt K: okay

173: Dr 9: see you (shaking hands)

175: Pt K: (walking towards door) thanks (.) bye (..) K

The patient indicates in line 161 that the antibiotic issue is not settled by suggesting that his improvement might be due to the antibiotics he has already taken, but he allows the discussion to move on by saying that he feels better anyway. The closing phase commences with the patient saying 'right (.) thank you very much' and standing up at line 167. The remaining turns are occupied with thanks and leave-taking. The patient coughs before he is out of the consulting room, whilst he is walking towards the door and whilst the doctor is orientated towards the computer. The single cough is the very last event in consultation.

It is of note that this patient has earlier said he does not suffer with a cough, and yet coughs several times in the last minute of the consultation at a time where there is potential conflict about the nature of the illness and need for antibiotics. These issues are left open, with the doctor allowing for the possibility of worsening illness (which might by implication then need antibiotics) (line 159). Gwyn suggests that cough can act as a discourse marker, functioning to keep interactions open (Gwyn 2003c). The final cough seems consistent with a rather unresolved situation: the cough as the last word portrays the illness as ongoing with the ending of the story yet to be decided. I

interpret events in this patient's consultation in terms of negotiation of identity and face in chapter 6.

In the two other examples of cough as the final event, it was also the case that the projected outcome of the illness was left open:

Example 18

Dr 7: obviously if it's going on and on and you're getting worse you know come back and we can re-think but I don't think it will

Pt M: I will yes

Dr 7: I'm sure you'll be (..) right as rain in a week

Pt M: (laugh)

Dr 7: okay

Pt M: thanks

Dr 7: (laugh) alright

Pt M: (laugh)

Dr 7: bye

Pt M: bye bye (..) kKK (.) km

And also:

Example 19

PT Z: that's great

Dr 9: okay so if things aren't settling down=

PT Z: okay

Dr 9: =in two or three days then come back

PT Z: right

Dr 9: alright ?

Pt Z: thanks very much indeed for your help (shaking hands)

Dr 9: okay thank you

Pt Z: thanks very much (.) bye (.) for now (..) kk km (exit from room)

Summary - closing phase

Coughing at the very end of a consultation is hard to interpret since it is not followed by any more talk. It is surprising that only three patients coughed in this position at the end of the consultation, since it is a time when talk is over and attention is turning to other matters, so would be a good time to cough if it was felt physically necessary (see below). Instead most coughing was co-ordinated with talk and placed within phases of consultation rather than in-between phases or at the beginning or end. Coughs in the closing phase seemed to accompany a sense that there are issues still unresolved.

Search for disconfirming evidence

Could coughing be simply a physiological necessity?

I re-examined the data to seek disconfirming evidence, in other words to seek alternative explanations and to guard against a misleading selection and presentation of data (Miles & Huberman 1994).

I have argued so far that coughing is used as an interactional resource by patients, so I sought to challenge this assertion by asking whether coughing is merely random, a physiological necessity with no particular interactional meaning. I analysed all of the cough clips with this possibility in mind, but focus here on coughing in conjunction with physical tasks (e.g. breathing deeply), coughing in phase changes, and coughing in the doctor's absence. These seemed to be situations in which coughing would be unlikely to have interactive significance.

Coughing as a physical response

Coughing sometimes followed laughing, crying and breathing deeply, which fits with a physical explanation for coughing. It does seem likely that the activities involved in examination would precipitate physiological coughing, for example deep breathing with stethoscope examination, having a throat swab etc, and I have described several examples of this type.

Coughing sometimes interrupted talk, but this was unusual:

Example 20

177 Dr 13: no (.) it's just a little bit of [pain-killer

179 Pt U: *[kk kk kk*

181 Dr 13: it's got a little bit of [vitamin C

183 Pt U: *[kk kk kk kk (..) sorry*

185 Dr 13: don't worry

187 Pt U: kk kk (.) kk

189 Dr 13: (...) and other stuff so you can actually take you know the usual amount of paracetamol

The doctor is interrupted at line 181 by the patient's fit of coughing, and she waits for the coughing to end before continuing at line 189. The patient apologises about his cough at line 183; this is an unusual acknowledgement of disruption caused.

There is no doubt that coughing is a sign of pathological processes in the body. It seems surprising therefore that so few coughs interrupted talk in the way shown in the above example.

Coughing in phase change

If coughing is simply used to clear the airway, it might be expected to occur at times of natural break in talk: perhaps during the time of transition from discussing the complaint to the examination phase, or on entry or exit from the consulting room. Most coughing was placed within rather than between phases (see page 151) and no-one coughed exclusively between phases.

The following example occurred during the transition from physical examination to the diagnosis/advice phase:

Example 21

(both off camera, physical exam in progress)

186 Dr 9: okay (..) good (.) that's (fine) (2.4) okay (3.6 walking to desk)

188 Pt Z: (out of view) kk kk km (2.0) kk kk km (5.5 walking back to seat)

190 Dr 9: okay (looking at desk and then computer)

192 Pt Z: (3.0 sitting down) kk kk kk km

194 Dr 9: from (.) from what you've (..) described

The end of the physical examination phase is marked with 'okay, good, that's fine' at line 186, and the beginning of the diagnosis/treatment/advice phase is marked with

'okay' at line 190. The patient clears his throat twice while both are moving across the room back to the desk following the physical examination. The patient clears his throat once more whilst sitting down, before the doctor starts his diagnostic formulation. There is no eye contact during the throat clearing; for the first two episodes, the patient is moving across the room. For the third, he is sitting and looking at the doctor (line 192). The doctor turns from the computer to make eye contact at line 194 as he begins his diagnostic formulation.

It is difficult to ascribe particular meaning to the throat clearing in this example. The throat clearing is not commented upon by the doctor, and it does not seem to have an obvious interactive function. The patient may simply have chosen a convenient time to clear his throat, a time when talk is difficult as the patient puts clothing back on, and is in the process of moving physical location. In the third episode of coughing (line 192), the patient's body orientation and gaze signal recipiency (readiness to begin talk) (Heath 1986) (see examples 1, 2 and 3) and it may be that the throat clearing complements this preparation for the next phase.

Coughing in the doctor's absence

In this example, the patient coughs while she is alone in the room. She is asthmatic, and her wheezy breathing is prominent.

Example 22

302 Dr 6: I'll just go and get the nebuliser alright ? (.) I'll be back in a sec (leaving room)

304 Pt DD: (gaze focused straight ahead into room) .HH (.) hhhh .HH (.) hhhh

306 Pt DD: .HH (.) hhhhh .HHH (.) hhhhh .HHH (.) H (.) .H Kh Kh

308 Pt DD: .HHHH (.) KKhh (.) KKhhh (..) KKh KKh

310 Pt DD: .uHHHH (.) KK (.) KK Kk (..) uuh (gaze towards camera and door)

312 Pt DD: (..) ooh Jesus wept (gaze forwards into room)

314 Pt DD: .hhh (.) hhh .hhh (.) huhh

[audible breathing continues until Dr comes back into room]

It seems on first sight that this is a good example of a cough which is physiologically necessary. The doctor has left the room to get a nebuliser machine to treat the patient's asthma. The patient is sitting forward and her breathing is wheezy and

prominent. She coughs after large in-breaths, and the coughs are loud and wheezy. The doctor is not present, so it seems that the cough could not have a communicative function in the consultation. However, the patient turns towards the camera and door of the room at the end of the cough sequence, and makes the comment 'ooh Jesus wept'. This remark seems to be a comment on the extent of her physical suffering. Who is the intended audience for this remark? It may be a commentary to herself, but the patient's gaze implies that it might be intended for the camera, or perhaps for the absent doctor. The comment acts in a similar way to saying 'oops' in public: the remark is made to an unspecified audience, and serves to account for behaviour without requiring a specific reply (Goffman 1981). The comment has given the coughing fit emotional and social meaning, highlighting the suffering which accompanies this physical event.

Summary – potentially disconfirming evidence

Cough in conjunction with laughing, crying or respiratory examination seems more likely to be physiological in nature, although as I discuss on page 169, the physical examination is also a time when the doctor's attention is focused on the patient's body, and doctors may therefore note coughing at this time. Most coughs did not interrupt talk, so this suggests that coughing was usually controllable. It seems significant that most coughs were not in phase changes, since phase changes could have been convenient times to cough between activities. All of the patients in this data set were complaining of respiratory symptoms, so coughing is to be expected in consultation. However, this analysis has shown that coughing is patterned rather than random. Analysis of cough in examination phase is difficult to interpret, since there was little talk. However, where coughs were co-ordinated with talk, they appear to have interactional significance.

Discussion

What does coughing accomplish?

(Why cough instead of talk?)

Coughing has not previously been systematically analysed as a potential communicative resource. This study demonstrates that despite being an apparently unremarkable event, coughing can have an interactional significance for participants in medical consultations.

I suggest that coughing can function in different ways according to the specific local communicative context. The local functions of coughing accord with the activities in

different phases of consultation, and there are patterns in common across different consultations.

In conjunction with verbal and bodily conduct, coughing is a resource in several different situations:

Waiting

Coughing plays a role in indicating that a patient is ready to tell their story. Doctors have more control than patients over the timing and topics addressed in consultation (Marshall 1988) and doctors must also accomplish institutional tasks which take their attention away from the immediate interaction with the patient (Heath et al. 2000). Patients must therefore frequently wait for doctors to be ready: posture, gaze and coughing can signal that patients are ready without calling a doctor's attention away from tasks they are engaged in.

Demonstrating symptoms

In seeking help, patients need to convey the 'doctor-ability' of their problem, in other words that the problem presented is of appropriate nature and timing, and amenable to treatment from the doctor (ten Have 2002) (see chapters 4 and 6). The patient's account must convey their suffering and present their request for help as legitimate, but also tread a fine line between being over-complaining and being neglectful. Patients need to show that they are responsible and capable, but at the same time defer to doctors' opinions (Bloor & Horobin 1975).

Consulting with URTI illness is particularly accountable, so presenting 'minor' symptoms as legitimate presents particular challenges for patients (see chapters 4 and 6). Many symptoms are not visible, and patients use gestures and body movements to demonstrate and enact their symptoms (Heath 2002): coughing can be used to directly demonstrate a problem, and serves as tangible evidence of suffering. Coughing was particularly associated with the receipt of a 'no problem' diagnosis: receiving a no-problem diagnosis and no prescription potentially threatens a patient's 'face' and makes their visit to the doctor more accountable (Ehrich 2003; Heritage & Stivers 1999) (discussed in chapter 6). In this context, a demonstrable cough may counter this potential loss of face, serving to display tangible physical illness.

Interactional difficulty

Coughing was frequently associated with interactional difficulty, for example difficulty answering the doctor's questions, misunderstandings, and in the context of a complaint (examples 1, 4, 6 and 8). It is unusual for patients to openly disagree with doctors (Perakyla 2006)(Atkinson & Heritage 1984): disagreement is interactionally 'dis-preferred' in English but also patients defer to doctors' institutional authority (see chapters 2 and 6). Despite the interactional difficulty in expressing disagreement, patients may find subtle ways to disagree with doctors' diagnoses, for example by introducing symptoms near the end of consultations, especially where the doctor's assessment or diagnosis does not appear to confirm the severity of a patient's problem (Perakyla 1998). In these data, coughing in conjunction with other paralinguistic features conveys a sense that issues were not resolved, resulting in continuing discussion of diagnoses. These resources can therefore indicate disagreement without being a direct challenge to a doctor's authority (see chapter 6).

Identity as a patient

The interactional functions associated with cough are all linked in some ways with 'being a patient': coughing may help to signal which person consulting is the patient; patients wait for the doctor's attention before telling their stories; coughing plays a role in providing tangible evidence of illness, helping to present the patient's illness as a legitimate and doctorable reason for consulting; lastly patients do not usually openly challenge doctors, and coughing may provide a subtle indication of interactional difficulty such as resistance to a 'no problem' diagnosis. I explore in chapter 6 how doctors' and patients' identities are constructed and negotiated in consultation.

This analysis has shown that coughing is used by patients as an interactional resource and that coughing is one of the non-verbal behaviours involved in the complex and subtle ways in which people communicate in consultation. I shall discuss the implications of these findings for researchers, teachers of medicine, doctors and patients in chapter 7, Discussion.

Chapter 6 -
Is a 'no problem' diagnosis really no problem?

The previous chapter analysed social interaction at a turn-by-turn level, noticing how coughing is used by patients as a communicative resource which contributes to moment-by-moment discourse identity and to identity as a patient. In this chapter I draw on a range of discourse analytic tools to explore the significance of URTI as a 'minor' problem, and to explore the challenge to doctor and patient identity and face presented by the 'no problem' status of URTI.

Identity and face in URTI consultations

The following is an e-mail from one of the participating doctors, sent to me in response to my invitation to participate in the study.

From: "Dr 9"
To: "Julia Bailey"
Sent: Thursday, February 24, 2005 7:48 PM
Subject: Re: cough and cold study

Dear Julia,

I'm still happy to be video'd for your study. I am at the ** all day monday to wednesday and thursday mornings. Afternoons are less busy, but mornings have more colds.

One woman came in with her 9 year old son and after I introduced myself to them both, she said, grumpily to her son, "go on, tell the doctor what's wrong"
"nothing, I'm better" he said quickly
She slapped him on the back of the head and said, "now don't mess me about, you've got a cold"
"But I'm ok!" he protested.
"He's had a cold for the last 4 days and I want you to give him something for it" she interceded.
I looked at her son and he shrugged.
"Don't look like that" she said angrily and slapped him again.
"Anything else.....?" I offered to the question to them both
"No" they said in unison, frowning.
"Well.... if you both think it's just a cold, then there's nothing I can do except to reassure you that it's going to get better in a

couple of days and medication is unnecessary"
"Aren't you going to give him any antibiotics?" mother asked, disbelievingly.
"No. They don't make any difference for a cold, they're entirely unnecessary" I replied, eyebrows slightly raised, 'honest guv' expression on my face.
"What about something for the cough"
"what have you tried?" I put to them both.
"nothing" in unison
"Well, cough medicines are as good as nothing, if you want to try something different, honey and lemon and hot water is worth a go"
"Why don't you give us cough medicines?" Asked the mother, irritability levels palpably rising.
"Because they don't make any difference. That is, they don't work" I replied quickly.
"Well give us some then" she retorted.
"...Cough.....medicines....do not....work.....They don't....make.....any.....difference....." I said v e r y s l o w l y.
"Well I'll have some anyway" Mother replied firmly.
"I'll tell you what. There are at least a thousand other medicines that are completely ineffectual, how about I give you some of them?"
"I'm not leaving until you give me some cough medicine" she said in a way and with an expression that meant she had a few more slaps stacked up.

"Alright," I caved in, "here you go. Now fuck off!"

Basically true. The catharthis is in the retelling.

This email is based on a real consultation which the doctor has represented as a story or drama (Reissman 1993). He uses reported speech as a device to invoke a sense of the events in consultation as realistic (Potter 1996a). This e-mail beautifully illustrates discursive ideas about colds, consulting, doctors and patients, and also alludes to the processes of mutual persuasion, presentation of self and threats to face that I have suggested are important in URTI consultations (see chapters 2, 4 and 5).

The cold in this email has an ambiguous status: the son's 'I'm ok!' in line 15 frames the cold as 'not illness', and the doctor concurs with this assessment, labelling it as 'just a cold' in line 22. The email alludes to the doctor's search for legitimate reasons for consulting ('anything else?', line 20), implying that a cold alone is not a legitimate reason. The mother does little work to account for her visit: she appeals to the duration of symptoms ('4 days', line 16), but gives no other context or explanation for why she has come or why now. Accounting for the visit is a chance for patients to convey that they are 'good' patients with legitimate reasons for consulting (Heritage & Robinson 2006) (see chapter 4), and the mother in this email does not take the opportunity to present herself positively. The doctor offers her another chance with his question ('what

have you tried?', line 31), but this is not taken up ('nothing', line 32). Failure to self-care violates an unwritten rule about seeking medical care: in this example, that patients should have taken reasonable measures to deal with problems themselves before seeking doctors' advice (Heritage & Robinson 2006).

The mother violates more expectations of patient conduct in consultation: she asks for/demands treatment early on in the consultation ('I want you to give him something for it', lines 16-17). It is the doctor's job and not the patient's to diagnose and suggest treatment, and patients usually defer to this institutional order, either not contradicting doctors' proposals, or finding subtle ways to contest them in ways which preserve doctors' authority (Perakyla 2006). The mother is portrayed as having unpleasant personal qualities (grumpy, demanding and aggressive) and this further undermines her 'good patient' status, since patients are ideally co-operative and grateful (see chapter 1).

The doctor offers 'reassurance' instead of antibiotics (lines 22-24) and the mother's disbelieving response to this is face-threatening for the doctor (line 26). The doctor continues, trying to 'sell' his advice to the patient through persuasive body conduct (his 'honest guv' expression, lines 27-29), building an identity as an honest, truthful doctor. This strategy partly succeeds, in that the mother drops her demands for antibiotics, but switches to a demand for 'something for the cough', by implication a medicine (line 30). The doctor then tries an appeal to rational argument, in other words that cough medicines do not work (lines 37-38). The patient is unresponsive to any form of persuasion, and her resistance is increasingly face-threatening for the doctor, since his advice represents his authority as a doctor. This attack on the doctor's face is turned back on the patient, where he constructs her as 'thick' as well as irrational, speaking very slowly in lines 40-41. The mother tries a last resort persuasive tactic: aggressive confrontation (lines 45-46) and the doctor finally 'caves in' (line 47). This loss of face for the doctor (his loss of authority, and his 'irrational' prescribing) is associated with very negative sentiments towards the patient (line 47). His strong negative sentiment allows him to regain some control over the situation, even if only to terminate the interaction (Goffman 1952).

Analysis of consultation talk in the previous chapter showed that patients are resourceful in presenting themselves and their symptoms to doctors, using body conduct and non-lexical resources such as coughing as well as verbal description to help build identities as legitimate patients. I have argued throughout this thesis that patients' visits for URTI are particularly accountable because of the morally ambiguous status of URTI illness. Patients face dilemmas about how to present themselves in

consultation, since they need to persuade the doctor of the legitimacy of their visit, but this is a high-risk strategy since doctors may re-cast patients' problems as 'no problem', resulting in loss of face for the patient. I also contend that consultations for URTI threaten doctors' identity as skilled and expert professionals, and that doctors' face is therefore also at stake. I argue that constructions of illness in consultation are important and consequential: for example, a 'Strep throat' is associated with antibiotic treatment and with patient legitimacy whereas a 'viral infection' invites no treatment, and implies that consultation was not warranted. Constructions of the illness, doctors' and patients' identities and maintenance of face are therefore all interlinked.

In this chapter I shall analyse a whole consultation to see how the patient asserts legitimacy despite consulting with a 'minor' illness, and how the doctor maintains legitimacy despite doing 'trivial' work. Differing constructions of 'URTI illness' are the doctor's and patient's weapons in the contest for the meaning of the patient's symptoms, so I will focus particularly on how the meaning of symptoms is negotiated in consultation and the consequences of this contest.

Methodology

Data

I am using a case study methodology in this chapter to explore in depth and in detail a 'telling' case (Patton 1990; Yin 1994). The literature review in chapter 1 and data presented in chapter 4 suggest that disagreements over the nature of the illness and legitimacy of consulting are most likely in consultations for apparently straightforward URTI symptoms. It also seems likely that patients and doctors will be more involved in face work in 'minor' consultations and those in which treatment is contested. I therefore selected the consultation of a patient with URTI symptoms and no other ongoing medical problems. There were differences of opinion about the appropriateness of antibiotics that were discussed in consultation. I also use an extract of symptom talk from another consultation to illustrate my approach to data analysis (see below). The core data for this analysis is a purposively selected consultation for detailed analysis. However, interviews are also sites for identity work as 'doctors' and 'patients' (Ehrich 2003; Kai 1996; Punamaki & Kokko 1995) (see chapters 2 and 3) so I have also drawn upon the post-consultation doctor and patient interviews as well.

Discourse analysis

My analytic approach in this chapter is eclectic. I draw heavily on conversation analytic principles, for example seeing talk as structured, patterned and orderly, and building social relationships turn-by-turn (see chapters 2 and 5). As in the previous chapter, I take social interaction to mean more than simply talk, so the analysis includes consideration of body conduct and the use of objects such as examination equipment (Heath 1986; Lachmund 1992). I draw on sociolinguistic analysis of talk in consultation as 'institutional talk', taking into consideration the attendant rights, obligations and constraints on form and content of institutional talk (see chapters 2 and 4). I draw on an analysis of rhetoric, in other words the persuasive design of the content and structure of talk and body movement (Atkinson 1984; Potter 1996a). From discursive psychology I borrow from work which explores the social construction of phenomena and links local discursive practices (face-to-face talk) to wider social discourses such as 'patient demand', 'overworked doctors', or 'minor illness' (see chapters 2 and 4) (Hall et al. 1999; Horton-Salway 2001). I have analysed talk in consultation and interview as 'accounts', focusing particularly on the constructive potential of talk and its social functions, in particular its evaluative and persuasive dimensions (Buttny 1993) (see chapters 2 and 3).

I kept in mind the question '*How is talk structured and what is achieved by particular designs of talk?*', focusing on how doctors and patients construct URTI illness, and how they construct identities as doctors and patients. I present a detailed analysis of a whole consultation (see page 192), but I shall first illustrate with an excerpt of symptom talk the way that I have drawn upon the above range of analytic tools to analyse interaction.

Discourse analytic view of symptom talk

The following clip is the first two minutes of a consultation between doctor 2 and patient D. This patient and doctor know each other quite well.

11 Dr 2: how can I help (..) Pt D**

13 Pt D: okay (sitting down very slowly) ohh (..) right my back's been playing me up (..) all week (.) since last week

15 Dr 2: yes (..) yeah

17 Pt D: um hhh (..) [I've actually come in (.) for

19 Dr 2: [have you been pain free with it (..) for quite a while

21 Pt D: no

23 Dr 2: no (.) no (..) never (turning to computer, typing)

25 Pt D: I just don't bother coming in (.) because (..) there's no point (.) it's the same old same old (.) 's tablets tablets tablets (..) umm hhhh I don't bother with it (.) but

27 Dr 2: yeah (..) but it's flared up more than normal

29 Pt D: last weekend (..) yeah (..) and um (..) to add to it I've got a cold (..) which (..) you know I don't really (..) come in here for a cold anything like that but (..) (Drs stops typing) over the last couple of nights (..) the situation's getting worse (..) I can't sleep (..) I can't turn (..) I can't even like I'm sitting down now (.) I've got to take my time (..) to get up (.)=

31 Pt D: =like when I'm going from one stance to the next (.) the pain it's (..) it's running right across my back (.) it's coming under my ribs (.) it's coming round the front

33 Dr 2: yeah

35 Pt D: and um (..) because of the cold (..) I can't sneeze (..) I can't cough (..) and (..) where I'm trying to stem it (..) when it comes (..) honest to god it's like I'm seeing stars (.) the pain that goes with it

37 Dr 2: yeah

39 Pt D: I don't know (..) what (..) I don't know what I've done

41 Dr 2: (typing)

43 Pt D: I don't know (..) trying to work out is it (..) a strain but a strain doing what (..) is it my kidneys I don't know what it is but (1.5) what's killing me more than anything is (..) I can't sleep I can't (..) move (..) even breathing (.) last night (..) I had to call my son at two thirty this morning (..) because I couldn't breathe the pain (..) you know and I thought no and I've got to (.) I don't know what's going on here

This extract can be read as a 'medical history' (Kumar & Clark 2005). A doctor's task from a biomedical point of view[29] is to translate the subjective patient world into an objective medical world (Cameron 2002). A 'medical history' is a highly condensed and formulaic version of patients' accounts (Atkinson 1999; Fleischman 2001). Seen from a biomedical perspective, the medical history in this two minute extract of talk can be summarised in just two lines:

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29 Primary care embraces a broad range of philosophical outlooks (see chapter 2) so there is not one unified 'biomedical view' of medical endeavour. By biomedical view here, I mean models of clinical practice which form the foundations of doctor training, for example, in undergraduate medical textbooks (Kumar & Clark 2005).

1/52[30] loin pain, radiating anteriorly, worse in last 2/7[31].
Exacerbated by movement, sneezing or coughing

A discursive perspective provides a very different way of understanding this excerpt of talk: I shall show in an analysis of this extract how DA can analyse the structure of talk and see how the patient's illness and also her identity as a patient are constructed in interaction.

This excerpt of talk can be understood as institutional talk which is specific to a medical setting, and this is reflected it's design (Drew & Heritage 1998; Sarangi & Roberts 1999). For example, identities as 'doctor' and 'patient' are quickly established: the doctor welcomes the patient by name and establishes the interaction as a 'service encounter' through the question 'how can I help?' (line 11) (Robinson 2003). The forms of talk, agendas and tasks are implicitly understood, for example, that it is the patient who has a problem, and the doctor who is to address this problem.

Both doctor and patient contribute to the medical framing of the patient's problems and their solutions. For example, patient D presents her problems in physical terms in response to the doctor's question 'how can I help?'. Questions are asked only by the doctor and the doctor generally directs the transitions from one phase to the next with body conduct or verbal markers like 'right', 'okay' and/or a pause to indicate a change in activity (not shown in the excerpt above). There are several events which would be accountable in ordinary conversation, but which attract no comment in this institutional context: for example the doctor types on the computer whilst the patient is talking (lines 23-29) and the doctor signals the start of a physical examination simply by picking up a thermometer. She places it into the patient's ear whilst talk is ongoing (excerpt not shown). The institutional roles as 'doctor' and 'patient' are therefore established partly by the surgery setting and un-stated inferences and expectations of the doctor-patient interaction, and partly by the content and structure of participants' talk (see also chapter 2) (Hall et al. 1999).

Presentation of one's self and symptoms can be seen as a performance (Heath 1986): I showed in the previous chapter how coughing is used as a resource to demonstrate respiratory symptoms (see chapter 5). In this example, the patient has pain which is conveyed from the very beginning of the consultation. She walks into the consulting room slowly and sits down gingerly, not responding to the doctor's 'How can I help?' in

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[30] One week

line 11 until she has sat down. She only makes eye contact and responds after a prominent 'ohh' (line 13). She uses body conduct to hold the floor, enacting her suffering with the doctor as audience (and possibly also the video camera) (Heath 2002).

The patient's very first utterance (after the social 'opening' phase of consultation) works to construct her illness and also construct her as a patient (line 13). Her first problem is back pain, and she uses the metaphor 'playing me up'. 'Playing me up' invokes images of a disobedient child, which frames the illness as a separate entity that is wilful but at the same time still controllable. 'Up' is a spatial metaphor which is very common in the English language (Lakoff & Johnson 1980) and its use here implies something alive and energetic. 'All week' (line 13) conveys that patient D has coped with the pain for a long period of time, but that it is now a reasonable time to seek help. In these first few seconds of interaction, the situated identities of doctor and patient are established (doctor as service provider, patient as service recipient). The patient has conveyed a need for help by demonstrating her suffering, doing identity work in casting herself as someone who has acted as a good patient in not consulting straight away, but then seeking help responsibly when it was no better (Halkowski 2006).

Her turn at line 25 contains a number of repetitions (I don't bother, same old same old; tablets tablets tablets) and this conveys a sense both of the unremitting nature of her back problem, but also the uselessness of attempts to get help for it. Multiple sayings can communicate a stance that the prior speaker has persisted unnecessarily in a course of action (perhaps here indicating that further questions on this topic would be unwelcome) (Stivers 2004). An upward, flicking-away type of hand gesture at the same time as 'tablets tablets tablets' followed by a sigh enhances the sense of her difficulty and her futile attempts to get help. In the context of this futility, it is not clear why she is consulting. The doctor puts forward the suggestion in line 27 that 'it's flared up more than normal'. Fire metaphors were common in talk about URTI in my data, with both patients and doctors drawing on metaphors such as 'flaring up' 'burning' and 'inflamed' to describe symptoms (discussed in chapter 2). Fire is something threatening and potentially out of control, but at the same time remediable if caught early enough. Patient D's use of the metaphor 'It's flared up' (line 27) conveys a sense that the illness has a will of its own, with connotations that it is not the patient's fault that this has happened. This is a good example of how the illness meaning is co-constructed: both doctor and patient refer to the illness (back pain) as an entity, as ongoing but

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[31] Two days

particularly bad recently, and playing up and flaring up, both of which are problematic but remediable.

In line 29, the patient acknowledges the contestable legitimacy of consulting with a cold, and pre-empts possible criticism (Goffman 1959; Potter 1996a) by pointing out that she would not normally consult with things like colds. This statement serves to convey that she is not a hypochondriac, and this is underlined by her previous account of suffering with her back pain but not bothering to come in. 'The situation's getting worse' (line 29) acts to justify the visit to the doctor for this reason, and at this time. This sets up the patient's help-seeking as an exceptional event (Heritage & Robinson 2006).

The patient then gives a detailed picture of the ways that her symptoms are affecting her (lines 29-43). The structure of her account is interesting: she gives three part lists with pauses between statements, for example in line 29 1) 'I can't sleep' 2) 'I can't turn' 3) 'I've got to take my time'; and in line 31: the pain is 1) 'running right across my back' 2) 'coming under my ribs' and 3) 'coming round the front'. Giving information in three part lists is a rhetorical device which helps to keep the listener's attention and amplify the strength of an assertion (Atkinson 1984). The doctor had been typing on the computer, but stops and listens during line 29. The phrase 'honest to God' serves to convey the veracity of the account, and is accompanied by a brief upward gaze (towards God, or the stars). The patient gives another three part list: 1) 'I can't sneeze' 2) 'I can't cough' 3) 'it's like I'm seeing stars'. It is difficult for patients to convey experiences like pain which cannot be directly witnessed (Heath 2002); the metaphor 'seeing stars' is an idiom which serves to sum up the patient's complaint about her physical symptoms (Drew & Holt 1988). The vague nature of the idiom and the fact that it is understood figuratively and not literally allows the doctor to concur ('yeah', in line 37). I have discussed the social actions of idioms in chapter 2, in relation to 'thinking positive'.

The patient has several ideas about what might be causing her symptoms, but she starts her conjecture by portraying her opinions as very uncertain ('I don't know (..) what (..) I don't know what I've done'), line 39. This formulation (professing uncertainty) allows the patient to air her ideas, but leaves the task of diagnosing to the doctor (Teas Gill & Maynard 2005). Illness of unknown cause is also more 'doctorable', in other words, accepted as a reasonable reason for consulting (Heritage & Robinson 2006). The patient then continues with talk about the effects of her illness, using the fighting metaphor 'killing me' (line 43) which constructs the illness as a malicious entity and

suggests ways of responding to it (for example, with pain-killers) (see also chapter 2). The symptoms in the three part list in line 43 are also extreme case formulations (Pomerantz 1986; Potter 1996b): 'can't sleep', 'can't move' and 'couldn't breathe' because of the pain. Extreme case formulations are exaggerations, rhetorical devices not to be understood literally, but used for dramatic and persuasive effect (for example she must have been able to breathe). Patient D's account gives specific details of events in the utterance 'I had to call my son at two thirty this morning' (line 43). From the point of view of establishing facts about the patients illness (in other words giving a medical history) this detail seems irrelevant, but this statement serves several functions. Firstly, specific details are more believable than vague or general statements (Potter 1996b); secondly, this statement serves to verify her account through citing someone who can corroborate her story through witnessing her suffering (Heritage & Robinson 2006); and thirdly, needing to disturb her son in the middle of the night conveys a sense of the severity of the illness and/or the worry that the illness is causing.

The patient attends once again to the legitimacy of her visit in line 43 where she says 'and I thought no and I've got to (.) I don't know what's going on here'. This utterance conveys that she had not unthinkingly sought medical help, but that the severity of her symptoms, the effects on her life, and her inability to account for the pain meant that she had no choice but to seek help. This conveys an identity as a reasonable patient, in other words as trying to endure her severe symptoms, but left with no choice but to consult.

Summary

From the point of view of establishing the 'facts' of the illness experience (the medical history), many elements of this excerpt of symptom talk are repetitive, irrelevant (e.g. specific contextual detail) or exaggerated (pain killing me): the medical history summary of the talk was only two lines in length. This discourse analysis shows how the content and the structure of symptom talk and body movement work to persuade the doctor of the legitimacy of the visit and that attention to the patient's illness is warranted. The patient's account conveys information about her illness which may help the doctor to reach a diagnosis and it also serves interactional functions, working to construct the patient's identity: here she conveys herself as a 'good' patient, in other words someone who normally deals with her illness without bothering the doctor. Her visit to the doctor is conveyed as justified this time since her symptoms are exceptionally severe, and they do not have clear explanations. Visiting the doctor is therefore positioned as the only reasonable way of responding. The nature of the

illness is consequential, reflecting back on the patient's identity. In this example, the illness is constructed as a separate and wilful entity, implying that the illness is not the patient's fault. Doctor identity is also constructed in this short extract of symptom talk, but I shall not analyse that here since this extract is mainly to demonstrate the discourse analytic tools that I draw upon. I analyse both doctor and patient identity in the case study (see below).

I have shown in this example how discourse analytic tools can unpick processes of social construction (of patient and of illness) and that 'meaning-making' is collaborative (Weick 1995).

I now turn to situations where meanings are contested, for example when there are disagreements about the seriousness of an illness or about appropriate treatment.

Contest over meaning of URTI symptoms

Patient K consulted Doctor 9 in a booked appointment on a Monday morning (It was doctor 9 who sent me the email discussed at the beginning of this chapter, prior to video-recording this consultation). They had not met before. The face-to-face talk was seven and a half minutes in length. Doctor 9's first language was English and patient K's was Spanish: patient K's English was very fluent, with occasional lexical or grammatical difficulties. I present an analysis of the whole consultation, but have split it into portions (shown in grey boxes) for ease of reference.

Opening phase and description of symptoms

3 Dr 9: Have a seat ?

5 Pt K: thank you

7 Dr 9: I'm Dr 9 (.) I'm (..) (shaking hands) [one of the doctors here

9 Pt K: [nice to meet you (..) aah (laugh) (both sitting down)

11 Dr 9: and er (..) what can we do for you

13 Pt K: right em (..) I started last Wednesday (...) with a little (.) it wasn't sore throat (.) it wasn't- (..) very dry em throat and all my em nasal (...) channels or whatever you call it in my ears (.) very itchy all around (..) em that was on Wednesday evening

15 Pt K: on Thursday evening (.) seemed like em you know everything was fine (..) nothing at all (.) but then on Friday- (.) er (.) I made an appointment on Thursday morning just in case and they gave me (.) today (.) of course

17 Pt K: .hh em on Friday (..) it came back (..) unexpectedly em (..) massively (.) like em (.) my sore (..) my throat was really really sore and my ears and etcetera (.) .hh I left work em (.) in the evening (.) em I went home (.) I had a fever (.) and that night was horrendous and

19 Pt K: Saturday was exactly the same (.) I (.) could barely swallow (.) and then .hh em in the afternoon I did something that probably I shouldn't which is taking some (.) em tablets I had left from a previous time .hh and em that's what I'm taking (.) it seems to be (.) getting better but em (.) .hh em em my glands are very swollen and em and (.) that's it really

Greetings occupy the opening phase whilst doctor and patient shake hands and then sit down (lines 3-9). The opening phase acts as an orientation for the transaction which is to follow (see chapter 5). The 'description of symptoms' phase is marked with the doctor's 'and er' followed by a pause before 'what can we do for you' (line 11). The

patient gives a fairly long account of his illness, with nods from the doctor but no verbalisations until his 'mm' in line 23. The patient gives specific details of what happened when, describing symptoms on different days: the illness seemed to start innocuously on Wednesday (i.e. six days before the appointment) with a dry throat and itchy 'nasal channels' (line 13). At this point, patient K portrays his symptoms in minimising terms, for example throat symptoms which did not even count as 'sore throat'. On Thursday patient K's symptoms seemed better (although he had already made an appointment 'just in case'). The detail given by the patient so far seems irrelevant, since patient K has told the doctor about minimal symptoms which then improved. What is the function of this detail? This account gives information which may be useful to the doctor in establishing a diagnosis (i.e. exactly how the illness started and when) but it also accomplishes identity work: in line 13 patient K conveys that he first interpreted his symptoms as minor and this serves to convey an impression that he had not over-reacted to his symptoms, but had interpreted them in a reasonable way (Halkowski 2006). In line 17 he explains that the symptoms recurred 'massively' and 'unexpectedly' whilst he was going about usual business. Patient K's mention that he was at work that day demonstrates that he had not prematurely adopted a sick role and taken time off, but was behaving in a socially responsible, morally admirable way. This detail serves to convey to the doctor that patient K should not be seen as a hypochondriac, but instead as someone experiencing unexpected symptoms which are not his own fault.

Patient K does considerable work in creating a persuasive account of his illness. Firstly he gives specific detail about what happened when, describing events on different days of the week: specific accounts are more believable and persuasive than more vague accounts (Potter 1996b). Patient K describes his symptoms in a list 1) 'really really sore throat' 2) 'my ears' (which he has described before) and 3) 'etcetera'. The 'etcetera' fills the third part of a three part list, the structure of which is designed to capture attention (Atkinson 1984) (see page 189).

Patient K accompanies his account with hand gestures: repeated stroking motions over his throat and face whilst describing sore throat symptoms, and finger motion to convey itchiness. Similarly to coughing (chapter 5), hand gestures animate verbal description of symptoms, and help to demonstrate to the doctor an illness which is not visible (Heath 2002). Patient K says 'that night was horrendous' and goes on to describe why: he could barely swallow (line 19). Patient K contradicts this assertion, since he must have been able to swallow fairly well to take the Amoxycillin tablets. Saying he could barely swallow is an 'extreme case formulation' with dramatic and persuasive effect

(Pomerantz 1986) (see page 190). This description and others ('it came back massively'; 'really really sore throat'; 'horrendous night' (line 17); 'my glands are very swollen' (line 19)) set up contrasts between the mild initial symptoms and the severe later symptoms. Such 'contrastive pairs' are persuasive in design (Atkinson 1984). He uses the term 'fever' (line 17) rather than 'I felt hot' or 'I had a temperature'. 'Fever' as a symptom has connotations of serious illness in medical and wider discourse (Kai 1998; Schmitt 1980)[32].

Patient K sought a doctor's appointment on the second day of his illness, and was given one for five days later (line 15). This could be seen as seeking help too readily, and is therefore 'accountable' (Goffman 1967). Patient K addresses this in line 17, describing how his request for an appointment has since become justifiable even if it was not then (his symptoms worsened considerably in the meantime). His account of measures taken to help himself is given in the context of a wait of five days for an appointment: he took Amoxycillin antibiotics which were left over from another time. This is also an accountable action, in that it is the doctor's job and not the patient's to decide what treatment is needed (Heath 1992) and patient K justifies his action by saying that they were given to him, presumably by another doctor. He quotes the drug name and the dose in a format used by doctors ('Amoxycillin five hundred' [milligrams]) which is rather unusual. Referring to antibiotics using medical 'code' (Gesler 1999) associates them with medical sanction, and diffuses the responsibility for taking them in that they were *given* to him (although on another occasion). These details help him to assert that his actions were legitimate in the face of a wait for an appointment, and with worsening symptoms.

Patient K pre-empts likely disapproval ('stake inoculation') (Potter 1996a) by saying 'I came back here probably for you (..) tell me off because I'm taking medicines without (.) having to do so' (line 25), with an appeal that really he had no choice 'but I'm sorry (..) I needed something' (line 31). They both laugh and this may signal the awkwardness of a situation in which the doctor's 'telling off' would be directly face-threatening (Goffman 1952; Jefferson 1985).

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[32] Too much must not be made of the meanings of single words since the meanings for any terms depend upon their context, although I argue later that doctors' choice of term 'virus' for URTI diagnosis has particular connotations which are consequential (see page 200)

What identity work has patient K accomplished so far? He has portrayed the reasonableness of his actions (and therefore himself as a person and a patient): his account is designed to persuade the doctor that he was not actively seeking a sick role, and that his actions in seeking help and in taking antibiotics were justified by worsening symptoms and a long wait for an appointment. Patient K constructs his illness as striking suddenly and unexpectedly, and therefore not his own fault. He does considerable rhetorical work (using extreme case formulations, 3 part lists, contrastive pairs and detailed description) to construct the illness as being much more drastic and severe than a mundane sore throat.

An open disagreement with the patient's assessment could be a humiliating threat to the patient's face and threats to face are generally avoided by both participants in social interaction (Goffman 1955). How therefore will the doctor respond to patient K's account?

The doctor's response

37 Dr 9: did you try anything else?

39 Pt K: no that's the only thing that I did (.) oh sorry paracetamol for the (..) em (..) for the fever and for the pain because all my body was aching my muscles and (..) and em (.) and that's it

41 Dr 9: have you had any trouble with your chest before any pneumonia

43 Dr 9: [or] asthma or [anything else

45 Pt K: [em] [no:: no no no no (..) no

47 Dr 9: any serious illnesses

49 Pt K: um (.) yes I had um actually TB (..) um back um (..) I don't know how many years ago but an awful lot of years ago and it was a mild form of TB and one of my glands here started getting bigger and bigger and bigger and then (..) and they put me on a treatment and em (..) for em (...) I don't remember how many (?) for a long time (.) plenty of tablets and (.) then as soon as I stopped the treatment because they told me to do so (.) it started growing back and em .hh so they took and they did a biopsy and they took a little bit of it and they put me on a treatment for a-nother period of time and then it went and (.) it was fine but em

50 Pt K: that's partly why I'm (..) em (..) [because (disease ?)

52 Dr 9: [right (..) and was it only in the gland (.) was it in your [chest at all ?

54 Pt K: [no just here (signalling left submandibular area) (..) just here=

56 Dr 9: =only in the gland

58 Pt K: (..) exclusively this gland (..) started growing (..) I still have the mark of the

60 Dr 9: yes

62 Pt K: biopsy (..) but em (..) that's it

64 Dr 9: okay and how does your (..) breathing feel at the moment ?

66 Pt K: em (..) when I breathe (.) it's like it feels a little bit itchy and it's starting to itch at the back of my throat and er (.) in my ears (..) but em (.) other than that (.) I can swallow as I said but it hurts

68 Dr 9: mm

70 Pt K: it's not- (..) nothing compared to Saturday was horrendous and (.) Saturday evening was .hhh probably the worst night in my life (laugh) it was terrible I just couldn't sleep for more than two hours because it got really really dry

72 Pt K: .hh I kept drinking em (..) water (..) as much as I could but em (..) it was such a pain I just (..) gave up really so em (..) that's it

The doctor defers giving an opinion on patient K's illness or his actions, but asks 'did you try anything else?' (line 37). This is a potentially face-threatening question, in that it could be taken to imply that patient K had not helped himself appropriately before consulting (see chapter 4). Patient K seems to understand it as a face-threatening question, since he explains that he had taken paracetamol (in other words he did actively try to control his symptoms) and takes the opportunity to further describe the severity of his symptoms, using the extreme case formulation 'all my body was aching' (line 39).

The doctor then asks about past medical events (pneumonia or asthma, lines 41 and 43). These questions are standard 'medical history' questions which seek further information to help interpret the presenting symptoms, both from a physical perspective (e.g. respiratory tract infections can exacerbate asthmatic symptoms), and from a psycho-social perspective (e.g. past serious illness may lead someone to worry more about subsequent symptoms) (Silverman et al. 2005). These routine history-taking questions are formulated in anticipation of negative responses (Boyd & Heritage 2006). Patient K emphatically denies trouble with his chest, pneumonia, or asthma (line 45) and doctor 9 asks about any (other) serious illnesses (line 47): patient K *has* experienced a serious illness, and he frames this information as if it may be surprising for the doctor (saying 'yes [..] actually'). Patient K gives considerable detail about the evolution and treatment of his TB. This passage (line 49) supplies some 'medical history' concerning TB (i.e. patient K had TB in one gland which required a long period of treatment before it went); the TB narrative also contributes to identity construction, constructing patient K as the passive victim of an illness, but also as a good patient (he took all the tablets, and stopped when told to). Mention of a biopsy lends veracity to this account, in other words, it was medically proved and patient K points to the physical evidence, a mark over his gland which is still visible (lines 58 and 62).

Patient K's interrupted remark in line 50 ('that's partly why I'm') seems to be supplying an explanation: his utterance is overlapped by the doctor's utterance (line 52) so we do not know exactly what is being explained or justified. This utterance implies that the TB account is functioning as an explanation (in other words, continuing 'face-work').

Patient K's answers to the doctor's questions from line 52 to 64 elicit information which seems to contradict his earlier account of severe symptoms: the TB was 'only' in the gland and not in the chest, his breathing feels a bit itchy, and he can in fact swallow (although it hurts). In line 70 patient K explains why this might be, and also pre-empts a charge that his symptoms do not amount to much: his symptoms were 'horrendous'

three days ago, described as the 'worst night of my life' (an extreme case formulation) but are now 'nothing compared to Saturday'. He gives an indication that he has tried to ameliorate his symptoms by drinking as much water as he could (another extreme case formulation), again conveying that he had taken reasonable steps to self-care before consulting. He uses the metaphor 'such a pain' which indexes literal pain as well as metaphorical pain (i.e. a nuisance). His symptoms were so troublesome that he 'gave up' (line 72). 'Gave up' is a fighting metaphor which relates to core metaphors in medicine such as 'medicine is war' with the patient's body as battle-ground (see chapter 2). Despite trying several things, patient K had not managed to fight off the illness.

Patient K's TB account describes a legitimate 'real' illness in the past, and this builds the picture of patient K as someone who does not 'cry wolf'. The patient's explanations about poor sleep and drinking water in lines 70-71 are not central to the patient's complaint, but provide contextual detail which acts to demonstrate the severity of the patient's illness. The structure of the account (giving specific detail) is more persuasive than giving a vague account (see page 190). The patient's account of symptoms could have ended at line 66: this additional information seems to indicate that the patient's legitimacy is still an issue.

The patient is doing considerable work to construct his identity as a legitimate patient, and the doctor has not said very much so far: the doctor's identity work is more evident in the next phases (physical examination, discussion of diagnosis and treatment).

Examination

74 Dr 9: right (..) okay well let's have a look at your (..) throat and check your glands now (unzipping torch case)

76 Pt K: they are both sides actually (.) em (..) in this one (.) (touching right side of neck) around here (..) but em (..) they hurt to the point that when I even move em (shaking head from side to side) (.) a little bit (..) em (..) quicky (.) quick (.) quicker sorry (.) quick (..) I can't speak (.) em (.) em (touching left side of neck)(.) and this one is exactly the same (.) but particularly (touching right side of neck) this one really hurts

78 Dr 9: (26 seconds standing up, examining submandibular glands) bit more round here that it's hurting

80 Pt K: yes (..) mm hmm

82 Dr 9: (6 secs preparing torch) (holding up torch) open your mouth wide (2.0) stick your tongue out (2.0) okay

84 Dr 9: and have you (..) you coughing a lot ?

86 Pt K: em (.) no

88 Dr 9: not really

90 Pt K: no (.) just em (..) sneezing from time to time now (.) but not coughing (.) and I haven't been coughing for the past three days four days so (shaking head)

The doctor's 'right (..) okay' marks the change of phase to 'examination', and this is accompanied by unzipping a small case containing examination equipment (an auroscope with a light, used for examining ears, mouth or throat) (line 74). Medical equipment carries with it connotations of specialised knowledge and expertise (Lachmund 1992); in fact any torch would be adequate for this examination, but the doctor uses one which is particularly designed for medical examination (shaped to fit ear canals) and kept in a black case. The equipment is not lying on the desk (as it could be since it is likely to be needed in an average surgery session) but is ceremonially unzipped (Simon 1990). The examination does identity work for the doctor, invoking doctors' rights to look at and touch patients' bodies (Heath 2006).

Despite this obvious change to 'examination' activity, patient K continues with describing his symptoms (a previous phase activity), explaining that both glands hurt, giving details of the consequences of this (even little movements are painful), and pointing out the most painful gland. How does this information function in the interaction? Further detail about symptoms directs the doctor's attention to a

problematic part of the patient's body: he spends a long time examining the glands, then looks at patient K's throat with the torch but does not look in his ears, despite earlier reference to ear symptoms. Patient K's talk in line 76 further elaborates his symptom story, making clear the practical consequences of the illness: this detail also serves to point to physical evidence of his illness and further justifies his decision to consult.

As Heritage and Stivers' work shows (discussed in chapter 2) doctors may comment on 'normal' findings whilst examining (Heritage & Stivers 1999). In this case, the doctor's only comment during examination is to clarify where exactly the pain is (line 78). The end of the examination is marked by 'okay' in line 82, and the doctor asks a new question about symptoms (coughing) (line 84). Patient K has not experienced coughing, but qualifies this negative answer by saying that he is not coughing *now*, and although not coughing, he is sneezing. In chapter 4, I noted that a great variety of symptoms were raised by patients, and that these emerged over the course of many turns of talk. Patient K's account is structured in this way, with new symptoms appearing gradually, even in the examination phase. This seems to imply a mutual search for a 'legitimate' symptom.

It is therefore still not clear that a legitimate 'doctorable' problem has been identified. In the next section, the doctor announces his assessment of the patient's illness.

Diagnosis, treatment and advice

92 Dr 9: fine (.) okay

94 Dr 9: .hhh (.) almost certainly (...) you'd be in exactly the same (..) situation you are now (.) if you hadn't taken any of the Amoxycillin

96 CG: right

98 Dr 9: so it's very unlikely (..) that they're the cause of you beginning to get better

100 Pt K: right (.) okay

102 Dr 9: yes (.) now the reason being because (..) you've almost certainly (..) got a (..) viral infection (.) which (..) tends to be really awful for a couple of days (..) and then gets better over a period of about (..) (I dunno) four (..) five (..) up to so many days (..) so whether or not you took the antibiotics probably hasn't had any effect (..) on the illness at all (.) in other words you've got (..) you would have got better anyway

104 Pt K: that's the nice English way of telling me off=

106 Dr 9: =(laugh)

108 Pt K: I'm sorry (laugh) (..) okay

110 Dr 9: but (..) but that's (.) that's er (.) the thing (.) with with colds antibiotics don't (..) they're not really indicated because (.) they don't actually make any difference

112 Dr 9: if you have a (.) pneumonia for example .hh or if you have a very bad (..) sinusitis .hhh the high fever that's not getting better for a few days and blood or something coming out of your (.) nose .hh then antibiotics are (..) or or can be useful (..) even then it's not a hundred percent (??) sinusitis

114 Dr 9: .hhh so (..) I don't think it's necessary (..) for you to have any more antibiotics (.) I think (..) you're beginning to improve anyway (.) you'll continue to improve

116 Dr 9: you probably haven't done any harm by taking them (..) the only risk of taking a few antibiotics (...) when they're not necessary is that (..) you might develop (..) another infection that's resistant to antibiotics so when you really do need them in the future (..) they're not so effective

118 Dr 9: so that's (..) the kind of (..) the telling off bit (.) if you like (..) that's the kind of worst bit that can happen

120 Dr 9: .hhh uum (...) but (...) I think you you your glands don't feel too bad (.) at the moment they're a little sore but they don't feel particularly big (..) your throat's a little red (..) but nothing more than that

122 Dr 9: .hhh I think you're almost certainly over the worst of it

123 Dr 9: and tomorrow you'll feel even better and by the middle of the week you'll be

124 Dr 9: back to normal [again

125 Pt K: [I hope so

'Fine (.) okay' precedes the doctor's diagnostic formulation (line 92), marking a change in activity from physical and verbal examination to 'diagnosis'. Doctor 9 delivers his diagnostic assessment between lines 92 and 104. He begins with a large in-breath before he speaks, acting perhaps as a moment to gather his thoughts, but also to claim the floor and make it clear he is about to speak (Schegloff 1996). Doctor 9 speaks slowly, pausing frequently within his utterances. This slow, clear articulation helps solicit attention and gives the doctor's talk an authoritative air (Atkinson 1984). He begins his diagnostic formulation by saying 'almost certainly'. 'Almost certainly' allows for the fact that he may be wrong, but is a formulation which may be harder to challenge than 'I think..' for example. He says 'almost certainly' twice (lines 94 and 102) and also 'very unlikely' (line 98), demonstrating a firm epistemological stance towards his conclusions (conveying a high degree of certainty) (Roberts et al. 2004).

Interestingly, a name for the diagnosis comes only after several lines of talk, brought in as part of the doctor's justification for his assertion that antibiotics are unnecessary (line 102). The diagnosis is given in vague terms ('viral infection') and its projected duration is also vague, but the doctor's formulation of the illness resonates with the patient's account: being 'really awful for a couple of days', and assigning a positive ending to the story ('and then getting better'). This design (matching the patient's account) demonstrates good doctoring (listening carefully) and it also has an interactive function: it makes it harder for the patient to refute the doctor's assessment since this makes it clear that the patient's view has been taken into account in the doctor's formulation (Maynard 1992). The doctor constructs the illness as having a will of its own: 'you would have got better anyway' and antibiotics would (probably) not have made a difference (line 102). Patient K's comment in line 104 shows that he has understood the doctor's assessment as a 'telling off'. This is a potentially delicate moment, with the doctor's assessment representing a threat to the patient's face. The patient skilfully refers to culturally specific modes of communication (in other words that English people are seen as polite) to make a comment that they both laugh at[33]. Patient K seems to accept a loss of face over the antibiotic issue, simply saying 'I'm sorry' and 'okay' (line 108).

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[33] Participants' ethnicity has not been directly relevant until this point, although patient K's linguistic slips marks him as 'non-English'. Both the doctor's and the patient's ethnicity is invoked at this point (as 'transportable identities', discussed in chapter 2), serving to defuse an interactionally awkward situation.

However, it seems that the situation remains unresolved, since the doctor continues with explanations and elaborations of his assessment (lines 110 to 124), during which patient K is completely quiet, although he nods periodically. The doctor formulates the illness as a 'cold' as if this label has been used already ('that's the thing with colds') (line 110). This formulation accomplishes three things: it categorises the illness as a cold, bringing into play assumptions which accompany this category of illness (see below). It also formulates this information as already accepted, and this is therefore harder to refute (Potter 1996a). Lastly, it is also an indirect and therefore face-saving way of formulating a 'no problem' diagnosis. The doctor contrasts the category 'colds' with dramatic, 'real' illnesses such as 'pneumonia', 'very bad sinusitis', 'high fever', 'blood coming out of your nose' (line 112), but makes the point that even then, it is not certain that antibiotics would be helpful. By referring to 'colds' in the plural, the doctor positions the patient's unique experience (the worst night of his life) as one example of a common occurrence (the many colds out there) and also portrays himself as being experienced and knowledgeable ('that's the thing with colds'), in this way framing himself as an authoritative source of advice.

The doctor generally uses non-medical language, drawing on medical lexicon in places (e.g. antibiotics 'not indicated' in line 110, 'resistant to antibiotics' in line 116). He allows for some uncertainty at line 114 ('I don't think it's necessary for you to have any more antibiotics'). The doctor then draws upon evidence from the physical examination to justify his assessment, acknowledging that he found some abnormalities but framing these as minimal, in other words glands that don't feel too bad, and throat which is a little red (line 120) (Heritage & Stivers 1999) (see chapter 2). Evidence from a physical examination is difficult for patients to refute since they do not have access to the information (Perakyla 1998). Patients do not tend to dispute the physical evidence that doctors offer, instead finding other ways of keeping the decision open, for example offering extra symptoms for consideration (Perakyla 2006) (although patient K does not do that). Doctor 9 becomes more authoritative by line 123 ('I think you're almost certainly over the worst of it'), finishing with a prediction about the illness' course which is quite precise: patient K will feel better tomorrow and be back to normal by the middle of the week (line 123). The doctor's expressions are idioms which give the illness narrative a happy ending ('over the worst of it', line 122; 'back to normal again', line 123). Idioms are vague and therefore hard to dispute (Drew & Holt 1988) (see chapter 2). The patient does not quite concur: he says 'I hope so' (line 125) which avoids directly disputing the doctor's formulation, but also allows room for the possibility that the patient will not be better as predicted.

There is a stark contrast between the patient's formulation of his illness as dramatic, severe, and unique (the worst night of his life) and the doctor's formulation of the illness as a viral infection or cold which is routine and evidenced in only minimal physical signs, in other words minor and unremarkable (Mangione-Smith et al. 2003).

The doctor's choice of names for the illness ('cold', and 'viral infection') carries with it implications for how the illness is to be understood (Edwards 1991): there are many terms that doctors could choose for a diagnosis, for example the medical terms 'pharyngitis' (inflammation in a particular anatomical location) or 'upper respiratory tract infection' (a more general term which contrasts with the more serious category of 'lower respiratory tract infections' such as pneumonia). Doctors can also choose lay terms such as 'sore throat', 'cold' or 'chest infection', and these lay terms were common in this data set (see chapter 4). 'Virus' or 'viral infection' was the most commonly chosen label for patients' diagnoses (chapter 4). Lay terms can carry the implication that the patient is more to blame for their illness and has more responsibility for getting better than if a medical term is used for the same illness (Ogden et al. 2003). Lay terms may also reflect poorly on doctors' professionalism. The doctor's choice of the term 'virus' is therefore significant: 'virus' derives from medical conceptions of illness, but lacks the usual precision and esoteric air of medical diagnoses (Fleischman 2001). The term 'virus' occupies territory between precise medical terms which have connotations of 'real' illness and lay terms which signify 'minor' illness. It also leaves the exact nature of the illness vague, and this makes it harder for patients to contest. 'Virus' as a diagnosis also serves delicate interactional functions for doctor and patient identity: it is a compromise which confers some legitimacy on the patient whilst also avoiding the threat to doctors' professionalism that a lay diagnosis might represent (Ogden et al. 2003).

The last excerpt finished with the doctor's prediction that all will be back to normal in a few days (without any more antibiotics) (line 124): how does the patient respond to this assertion?

Negotiation

127 Dr 9: yes (..) I think you look [fine

129 Pt K: [fantastic

131 Dr 9: (..) I would suggest (..) yes paracetamol or ibuprofen is a good (...) symptomatic treatment (..) um (.) and you'll be fine

133 Pt K: fine (..) okay (.) well (..) (laugh) thank you very much

135 Dr 9: (laugh) [anything else ? [(laugh)

137 Pt K: [I won't take antibiotics again [(.) no not at all

139 Dr 9: no (.) (?) there are times when they are useful but

141 Pt K: KK km

143 Dr 9: but (..) not necessarily for (.) for this sort of thing

145 Pt K: okay (..) (??) yes (.) just waiting until it goes really

147 Dr 9: yes and a (.) 'nother day or so

149 Pt K: [KK km

151 Dr 9: and [you'll be completely fine

153 Pt K: fine well thank you very much

155 Dr 9: alright ?

157 Pt K: (smile/laugh)

159 Dr 9: if you don't think it (.) if you think it's getting worse again then obviously let us know

161 Pt K: well (..) hopefully not (.) because I feel much better today (.) regardless whether it wasn't the antibiotics but [(..) (laugh) but I do feel much better

163 Dr 9: [(laugh) good

167 Pt K: right (.) thank you very much (standing up)

169 Dr 9: that's fine

171 Pt K: okay

173 Dr 9: see you (shaking hands)

175 Pt K: (walking towards door) thanks (.) bye (..) a K

In line 123 the doctor says 'I think you look fine'. This is a reporting of sensory observations (Heritage & Stivers 1999) and this utterance sums up the physical examination evidence that the doctor has given in line 120. This reporting of a doctor's sensory observation is harder to dispute than saying, for example, 'I think you are fine', and is also rather vague (like the doctor's idioms). The patient responds by saying 'fantastic', in overlap with the doctor, signalling agreement (Pomerantz 1984). Saying 'fantastic' positions the doctor's statement as 'good news' (Maynard & Frankel 2006). This is perhaps rather a surprise, since the doctor's 'no problem' formulation of the illness contrasts dramatically with the patient's construction of the illness. Patients rarely openly dispute doctors' diagnoses, even when given opportunities to do so (Heath 1992). Heath suggests that this preserves the 'expert' status of the doctors' opinions. Avoiding contesting the doctor's formulation therefore also avoids a challenge to the doctor's face as professional and expert. Receiving the formulation as good news also redefines the patient's situation from being face-threatening (receiving a 'no problem' diagnosis), to being face-saving (the sharing of good news that all is well).

I have discussed the potential significance of coughing in this latter part of the consultation (see chapter 5, example 17), noting that the placement of coughs seemed to act as resistance to the doctor's 'no problem' formulation (lines 141, 149 and 175), and helping to keep open the dialogue about the nature of the illness. In this analysis I shall explore identity-work and face-work in this last portion of consultation.

The doctor's advice-giving in line 131 starts 'I suggest', implying that something new is to announced, but is then modified to 'yes paracetamol', acknowledging the earlier information that the patient is already taking paracetamol, and ending with a vague idiom ('you'll be fine'). Advice-giving is usual in consultation (Byrne & Long 1976). However, the doctor's advice about pain-killers does not constitute specialised knowledge and here seems rather superfluous. As observed before, the patient's response in line 133 ('fine, okay, thank you very much') is turbulent: the doctor keeps open the ongoing talk by asking 'anything else?' rather than drawing the consultation to a close. This overlaps with the patient's 'I won't take antibiotics again' in line 137 which re-opens the topic of antibiotics. The doctor's explanation is face-saving for the patient: he allows for the possibility that the request for antibiotics *could* have been appropriate, but 'not necessarily for this sort of thing' (line 139-143).

The patient then draws on a metaphor that they can both agree on: 'waiting until it goes'. This travel/time metaphor contrasts with 'battle' metaphors associated with treatment such as pain killers (used earlier by the patient, line 72) (see also chapter 2).

A repetition of the idiom 'you'll be completely fine' is overlapped by the patient's coughing in line 149. In lines 153-159 (for the second time) the patient offers a possible closing utterance ('fine well thank you very much') but this is not taken as an ending by the doctor who instead re-opens discussion, suggesting that issues are not resolved. This time the doctor addresses the discrepancy in assessments of the severity of the illness, by allowing for the possibility that it may in fact get worse rather than better. This is another move to preserve the patient's face, allowing an opening for the patient to re-consult rather than simply being told his visit was inappropriate.

The patient's response concurs with the 'good news' formulation ('I feel much better today') (line 161), but leaves it open as to whether the antibiotics may have helped him. 'I do feel much better' ends the patient's narrative on a positive note upon which the doctor can express approval ('good' in line 165). This positive formulation is face-saving in that it explains the minor examination findings, and also means that there is therefore no need for antibiotics, so this repositions antibiotics as not needed rather than refused. However, if the patient *is* feeling better, this raises the question of why he has attended. The doctor does not pursue this question, and it is the patient who initiates the closing phase, saying 'right (.) thank you very much' and standing up (line 167). This is perhaps also a face-saving action in that it is the patient who controls the end of the interaction rather than the doctor: all previous phase-changes have been controlled by the doctor. The remaining turns are occupied with thanks and leave-taking.

The patient coughs before he is out of the consulting room, whilst he is walking towards the door and whilst the doctor is orientated towards the computer. There is a risk of over-interpreting this cough, since there is no talk following it, and the doctor is orientated away from the patient by this time. However, other coughs in this data set are clearly involved in patients' presentations of self and symptom (see chapter 5), and this patient does not have cough as a symptom so his coughing perhaps needs more analytic explanation. As I showed in chapter 5, there were other examples of cough right at the end of consultation in association with somewhat unresolved situations (examples 18 and 19). The single cough *could* perhaps be seen as the patient's last 'presentation of self'.

Interaction in this last section is rather turbulent, with laughter from both doctor and patient, coughing from the patient, and re-opening of the topics of antibiotics and the severity of the illness. Despite this turbulence, the doctor and patient collaboratively construct the illness as much more benign, re-defining its metaphorical associations,

and casting it as something that will go away on its own. The 'good news' formulation of the illness is face-saving for the patient, reformulating the situation as 'fantastic' for him instead of face-threatening. In this situation, antibiotics are simply not needed rather than being refused.

Discussion

Is a 'no problem' diagnosis really no problem?

This analysis shows the way that the doctor and the patient are involved in mutual persuasion. The patient's account is designed to persuade the doctor of the severity of his illness and therefore its 'doctorability' (Bloor & Horobin 1975). The doctor's account is designed to persuade the patient that the illness does not constitute a doctorable problem, and that no treatment is therefore necessary (a 'no problem' diagnosis).

Patient K's account is rhetorically structured to persuade the doctor that his illness is severe, but also that he is a legitimate patient (Roberts et al. 2004): he presents an identity as a 'good patient', in other words, seeking help at a reasonable time for reasonable reasons with an illness that he should not be held morally accountable for.

The doctor talked much less than the patient, but has the advantage of institutional authority and privilege to be persuasive: the doctor's account is rhetorically structured to persuade the patient that his illness is not a doctorable problem and that no treatment is necessary, and he also uses 'evidence' from the physical examination to support his position. The doctor's talk and actions construct his identity as an 'expert' and is this view which ultimately prevails. Whilst the patient's views are aired, the treatment decision is not mutually agreed (Elwyn et al. 1999).

The doctor's diagnosis and treatment advice represent a profound threat to the patient's face, since a 'no problem' diagnosis implies that the patient should not have consulted, and the patient's taking of antibiotics is therefore cast as inappropriate. The doctor account is carefully designed to save the patient's face, for example using vague and indirect formulations instead of directly contradicting the patient's construction of the illness. Both collaborate to redefine the situation from being a face-threatening refusal of treatment to being the good news of being nothing much wrong. The illness is co-constructed as being something that will go away on its own instead of something which needs to be fought with medicines.

This consultation contrasts with the scenario described in doctor 9's email on page 181. In the email, the patient (the mother) does not present herself as a 'good' patient: she questions the doctor's advice and therefore his authority as a legitimate doctor, and the situation leads rapidly to a confrontation, with loss of face on the doctor's part through feeling pressurised into 'inappropriate' prescribing.

The post-consultation interviews indicate that issues of legitimacy and face were salient in the consultation I have analysed. Patient K alludes to legitimacy (wasting time with an 'irrelevant' illness, line 47), and also to issues of face (feeling apologetic, and the doctor's reassurance, line 51):

Interview patient K

47 Pt K But I try not to go unless I have to go, particularly because we are working and that means, you know, wasting time at work and, well, **wasting time with the doctor if what we have is just irrelevant**. That was in the way the feeling that I had the other day when I left, I felt better because it was like OK, it's disappearing, it's going away, but I felt like, oh God, I **felt like I've wasted my time and his time**, **because I came here just to tell me that it will go**, type of thing. But, erm ... but it was like that. He couldn't do anything else apparently because that's the way it is, so that's fine.

48 JB Yes. Mmmn. Did that feel a bit difficult then at the end?

49 Pt K Pardon?

50 JB After the consultation, were you left feeling a bit, erm, unpleasant in a way?

51 Pt K No, no, no. Not at all. He was really nice and yes, he was very nice and, erm ... well, **I guess I was a little apologetic, that's why he was a little bit like, don't worry, it's all right**, but just for you to know that antibiotics are doing nothing for what you have type of thing. No, I just meant probably because I'm expecting from the doctors not just to listen to me, which he did very nicely and comforted me, you know, by just saying, you know, it's going to go away. But also because I was probably expecting a tablet, you are going to take this magic pill, you're going to take this and it's going to be fantastic. But, erm ... and that didn't happen, because **he told me it wasn't appropriate**. So, erm, fine.

A 'no problem' diagnosis also disappoints patients' expectations of doctors' abilities to prescribe (also quoted in chapter 4). This quotation alludes to the linkage of face with the refusal of antibiotics. Patient K said in interview:

Interview patient K

16 JB Yeah. So when you went to the doctors, did you have something in mind? What were you expecting?

17 Pt K Well, erm, when I go to the doctors, what I'm always expecting is for them to listen, erm, which is not very usual, unfortunately. And, erm, to listen and to understand that if I'm going to the doctor it's because I'm not feeling well, and you know sometimes we create ourselves too much expectation and they can not do what we want to do, but, erm, **I would be very happy if they give me just a pill and say this is going to be for you to get better, even, you know, the pill is em just nothing**. But, erm ... but this time he finally **said that I didn't need anything, so I trusted him and went away, really! Feeling much better, that's true!** *(laughs)*

18 JB You were hoping for some sort of medicine?

19 Pt K I was, yeah. I don't know whether it's because **I associate doctors with medicines that when I go to a doctor's, I'm expecting a solution for a complaint really**! *(little laugh)* So, yes, like basically, if you go to the doctors, they have to give you something good or something for you to get fine, but, erm ... but yes, I guess when I go to the doctors, I'm expecting to receive something.

20 JB And did you feel listened to when you went the other day?

21 Pt K I did, indeed, yes. He was a very nice guy and em and I ... I guess that I knew that I did something wrong which is em take some tablets or some antibiotics before; I didn't know whether they would work or they didn't, I just took them because I needed something and the appointment was on Monday, and this was on Thursday and I was feeling bad. But, erm ... but he was very nice and he was, erm, very understanding and, erm, **he told me basically what you have done is pointless - in a very nice way, without making me feel bad** and I guess it's good.

The post-consultation interview points to doctor 9's awareness of the persuasive function of physical examination and the link with his legitimacy as a doctor:

Interview Dr 9, line 85-94

(play more tape of Mr Pt K, where doctor examines him.)

Dr 9 I have no idea why I do this. I mean, it's not going to change what you're ... what you're ...

JB So you don't know why you examined him?

Dr 9 Oh, all the examining you do with these coughs and colds and these patients are quite patently well people who've come in and have got no signs of any respiratory distress and no history to suggest any respiratory problems. I mean, I know, maybe one in a hundred chests you listen to, you're actually thinking, I really ought to have a good listen here.

JB Yeah. So what do you think that's about ?

Dr 9 Oh it's meeting patients' expectations. Yeah, people very frequently I think complain the doctors haven't ... you know, the doctor didn't even examine me or my child or whatever! You know the child that's come in, that's been coughing for three days, he's running around the room causing a riot, who's bouncing up and down, stuffing their face with sweets, hasn't got pneumonia. Like, what's the point in listening to the chest! Look like listening to the chest it's to make sure that the mother's reassured that they've been properly looked at. It's not because you think you'll find anything.

JB Yeah, so with him it was a bit of a ...kind of a ...?

Dr 9 Oh yes. And I needed to ... when I ... **I knew, you know, within I think two minutes and two seconds of him coming in that he had a cold and I wasn't going to give him any more antibiotics**, or at least he didn't need any. And then I was already thinking subconsciously, OK, when this point comes, **I need to be convincing**. **Saying, having thoroughly examined you, I can say confidently that you don't need any**. But if you just say, "Yeah, yeah, stop there, look, you've got a cold ...! Next!"

JB Yes, you think **you wouldn't have the legitimacy somehow**?

Dr 9 Yeah. Yes, and it's not just a cold legitimacy, you don't just ... you know, he might come back with something more serious next time, or even this time; it might just be his way in, yeah. But I think when you develop relationships with patients as a doctor, that's part of it; you deal with the kind of colds and stuff, and then once you've done that a couple of times then you can start to say to them, "Now stop right there, because we've been through all this before, you know it's a cold. It's like, let's just get on to something that's a bit more important." But you can't behave like that until you've met them a few times, and that's why I think consistency of care is so important. And that's why I think colds actually are quite important. If you have a ... that's why I worry that in the future, you know, where everything that is just supposedly trivial is farmed out to the nurse and what-have-you, of somebody comes in with something more serious and they haven't already built that relationship up over so called trivial coughs and colds.

I have shown in this analysis how doctors' and patients' legitimacy and 'face' are at stake in a contest to define the meaning of symptoms (as significant, or alternatively, no problem). Doctors' and patients' interests conflict: for example, prescribing antibiotics may legitimate the patient but discredit the doctor.

Reverse medicalisation

One of the concerns about prescribing antibiotics is that it 'medicalises' URTI and encourages future attendance for minor symptoms (Little et al. 1997) (see chapters 1 and 4). There is a large sociological and anthropological literature which describes the extension of influence of medicine through the labelling of problems as medical problems (Cowley et al. 2004). There is dispute about the status of many problems: for example child-birth, chronic fatigue syndrome (ME), or repetitive strain injury amongst many (Arksey 1994; Horton-Salway 2001; Oakley 1980). Medical labelling (assigning a

diagnostic category) is an important part of the process of medicalising, and physical indicators of disease are also important in bringing conditions into the medical realm.

Medicalisation carries with it the risks of iatrogenesis, the harms that can come from medical intervention (Illich 1975), but there are also potential benefits, for example gaining the legitimacy of a 'real' problem. Conditions seen as medical problems may also be associated with less moral disapproval than those classified as social problems (for example, seeing alcohol use as an illness rather than moral weakness). In some cases, things become de-medicalised; for example, homosexuality is no longer formally classified as an illness (Foucault 1976).

There is a process of de-medicalisation occurring in this consultation: the doctor minimises the significance of the physical findings and contrasts the patient's illness with illnesses which are clearly within the medical realm (pneumonia etc) (page 203). His choice of diagnostic terms also de-medicalises ('cold', 'viral infection') (page 204), since these are not medical diagnostic categories. Finally, the doctor withholds a prescription, all of which help to construct URTI illness as not a medical problem. The nature of the illness, including its name, its attributes and its associations, is highly consequential for the outcome of interaction between doctor and patient.

In summary, I contend that a 'no problem' diagnosis does present significant potential problems for both doctors and patients, but that threats to identity and face can be negotiated sensitively and co-operatively. However, co-operation does not also mean collaboration, since it is the doctor's formulations of problem and treatment which prevail.

I discuss in the next and final chapter the practical implications of the importance of face and legitimate identity for doctors and patients in URTI consultations, and also the implications of discursive approaches to consultation analysis for primary care research.

Chapter 7 - Discussion

In this final chapter I shall discuss the implications of my analyses (coughing in consultation, doctor and patient identity and face-work). I shall also summarise the methodological journey and discuss where this points to next, in other words the implications of this work for researchers, practitioners, patients, medical educators and for me personally.

The methodological journey

This thesis has represented a methodological journey in which I have explored different ways of understanding interactions between doctors and patients in URTI consultations. In chapter 1, I illustrated a quantitative, population view of patterns of illness, consulting and prescribing in consultation, and gave an overview of qualitative and quantitative explorations of doctor and patient perspectives. In chapter 2, I discussed the advantages of qualitative approaches for understanding social interaction and introduced discursive approaches, focusing on conversation analysis and discourse analysis. I then went on to think about the implications of a discursive approach for my research design in chapter 3. In chapter 4, I set the study in an ethnographic and discursive context and in chapter 5, I explored a conversation analytic view of URTI consultations, describing the interactional function of coughing. In chapter 6, I explored a discourse analytic view of interaction in consultation, describing the implications of the 'minor' status of URTI illness for doctor and patient identity and face. I have described original 'findings', but perhaps more importantly this thesis critiques traditional social science research methods. In this chapter I will discuss the implications of this work, in other words the transferability of findings and the implications of the methodological issues that I have raised.

End of this research journey: where am I now?

This methodological exploration has been quite a long and difficult journey which I attribute mainly to being a medical researcher trying to learn from several different social science disciplines (see chapter 2). I discuss two challenges: firstly, my shift from a positivist to a constructionist research paradigm, and secondly, the difficulty in accessing training in discourse research within medicine.

Moving from a quantitative paradigm

I have had a long-standing interest in critical thought, for example Marxist analysis of social inequalities including doctor-patient power dynamics (Marx 1992; Waitzkin 1989), feminist interests in the socially constructed nature of identity (Wilkinson & Kitzinger 1995), and Foucauldian interest in wider social discourses and the way that these can constrain possibilities of thought and action (Armstrong 2002; Foucault 1973). Despite my critical interests, it has been quite difficult to shake off some assumptions implicit in medical science (Gordon 1988) (see chapters 1, 2 and 3). For example, I found it difficult to learn to have an inquisitive attitude to data without a clearly defined a-priori research question. 'Analytic noticing' rather than exploring hypotheses feels more creative but is also unsettling since it is harder to plan and structure research, and I was very uncertain that anything interesting would emerge.

I found it hard to move away from a quantitative paradigm which values large sample sizes, representative sampling and procedures to check reliability, and to feel comfortable with the aim of generating theoretical understandings rather than statistically generalisable results (see below). A discursive understanding of the nature of talk in interviews and an increasing awareness of my own role in co-constructing interview data (see chapter 3) meant that I found it difficult to clarify for myself (and for interviewees) the aims of my interview questions. Philosophically, I shifted from wanting to know for example '*What do you think about cough and cold consultations?*' to '*What ideas (discourses) do you draw upon to talk about cough and cold consultations?*' or more precisely *'What discourses shall we both draw upon today to talk about cough and cold consultations?'*

I decided to write the PhD in the first person to reflect the position that this research is an interpretative endeavour (see chapters 2 and 3). It was hard at first to alter my writing style to the first person and to use active tenses since this appeared 'unscientific' and somehow rather egotistical in comparison with the passive, anonymous voice of scientific medicine (Gordon 1988; Morse 1997a). The iterative nature of qualitative endeavour and the absence of a linear narrative for the project (hypothesis-experiment-results-conclusion) (Morse 1997a) made structuring the thesis more challenging. For example, I have included brief analyses of data in chapter 2 to illustrate methodological points; the literature review influenced analytic ideas throughout the thesis; and data analysis is integrated with discussion of findings. The metaphor structuring medical research is usually a mystery, (puzzle, clues and then a

solution) whereas I have drawn upon metaphors of travel and vision which yield a less linear or tidy narrative structure for the thesis.

There are dilemmas about how to have a productive dialogue between social scientific and medical academic communities (Roberts & Sarangi 1999) and I found it challenging trying to write in a way which would be meaningful for both communities, communicating across disciplines and across paradigms[34] (Roberts & Sarangi 2003). As discussed in chapters 2 and 3, medical (positivist) paradigms reflect more epistemological certainty than constructionist paradigms, seeing the researcher as a separate, objective observer. In contrast, constructionist paradigms position research as interpretive, framing 'findings' as more open to discussion and debate than the 'hard' numerical results of natural science, and this is reflected in social scientific writing styles (Roberts & Sarangi 2003). The products of qualitative research often comprise ideas for discussion and debate rather than succinct 'conclusions'.

Medical journals have shorter word limits and medical conferences have shorter presentation slots than those of social scientific disciplines and it is difficult to convey social scientific ideas in the concise, formulaic way of medical academic genres (Morse 1997a). Qualitative research is seen as less reliable in comparison with the 'gold standard' of quantitative randomised controlled trials (Haynes et al. 1994; Sackett et al. 1997) and is much less likely to be drawn upon as evidence to underpin guidelines for clinical practice (Burgers et al. 2002). For example, the difficulty in getting qualitative research published in 'high impact' journals reflects the lower value placed on qualitative 'evidence' and the lower priority given to theoretical research within clinical medicine (Campbell et al. 2003; Morse 1997a).

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[34] Broadly, and to over-simplify, communicating between positivism and constructivism (see chapter 2)

Qualitative training and support

All PhDs are potentially rather lonely endeavours, since the exact research area and/or methodology is unique (Phillips & Pugh 2000). However, this is amplified for qualitative researchers in scientific fields (Yardley 2000), and even more so for discourse researchers since expertise is scattered. Courses offered as postgraduate research training in medicine are orientated towards the needs of quantitative laboratory scientists. In response to this, a colleague and I set up a PhD group in 2004 for students in health settings who are using qualitative approaches, and this has been a useful forum for support and methodological debate[35]. Group members have come from as far away as Plymouth and Southampton, although most remain in contact via the e-mail list rather than attending meetings. The group has offered informal support as well as lively methodological debate.

Discourse analysis draws from many different academic fields, and I found it difficult to decide which literature would be relevant because of the enormous potential quantity and the unfamiliar language and concepts of different disciplines. Many relevant social science resources are in books or journals which are not available online. Partly because of the changing direction of the research, it was only in the third PhD year that I accessed appropriate teaching about discourse analysis, taking the Open University distance course entitled Discourse Analysis (Wetherell et al. 2001). I would have liked to have studied conversation analysis in more depth, but this was not feasible because of time and the availability of training. There is a need for a multi-disciplinary MA-level or MSc-level module in discourse analysis in health, and in response to this, I am helping to establish a module on medical discourse analysis at King's College London with one of my supervisors (Celia Roberts) and others.

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[35] http://www.ucl.ac.uk/pcps/research/qualres/index.htm

Personal implications of my methodological journey

Despite difficulties along the way, the PhD journey has been very fruitful for me. I have found it exciting and satisfying exploring discursive methods, and this research has given me insight into difficulties and dilemmas in URTI consultations that I experienced as a GP (see chapter 1 and discussion below). Engaging with discursive critiques of research methods has also helped me to make sense of puzzles about research processes, for example: 'what is the epistemological status of findings?', 'how does the researcher influence findings?' (in other words, can research be 'objective'?), and 'what is the nature of social reality?' (see chapters 2, 3 and below).

As well as realisations about the nature of 'front-stage' research processes such as collecting and analysing data, discursive perspectives have helped me understand 'back-stage' processes in the production of research (Sarangi & Roberts 1999). Academic ideas are produced and contested within the context of social relationships: understanding concepts such as footing, identity and face allows insights into how research and researchers are produced (Morse 1997a). For example, presenting research at academic meetings involves a presentation of self and findings in a way which is persuasive (see chapter 6): the research is likely to be more credible if the presenter constructs an identity as confident and authoritative but not arrogant. In another example, footing and face are important in the supervisor-supervisee interaction: footing may be peer-to-peer, counsellor-client, or teacher-pupil for example. Footings and definitions of the situation need to be clarified for a productive relationship, and criticism needs to be managed delicately to avoid problems such as misunderstandings and threats to face (Li & Seale 2007). To give another example, academic writing can be understood as socially situated: this thesis is recognisable as belonging to a particular genre ('social scientific debate'), is underpinned by a narrative structure, and is rhetorically structured to make sense and be persuasive. Insights from discursive perspectives have helped me to understand 'how research is done' in a wider sense than simply learning research methods.

I now discuss the implications of this thesis for doctors and patients in URTI consultations and for primary care consultation research in general.

Transferability, credibility and plausibility of findings

There is vigorous debate about how the quality of qualitative research should be assessed (Chapple & Rogers 1998; Elliott et al. 1999; Malterud 2001). The terms 'transferability', 'credibility' and 'plausibility' (instead of 'statistical representation', 'validity' and 'reliability') reflect the different philosophical assumptions which underpin a constructionist paradigm, as I discuss below.

Transferability

Transferability is the theoretical applicability of findings to other settings or situations (Pope & Mays 2000). Sampling in qualitative research aims to explore new ways of understanding or thinking about issues rather than to represent populations in a statistical sense (Morse 1997b; Wetherell 2001): sampling is driven by theoretical considerations, and the findings of qualitative research are theoretically applicable rather than statistically generalisable. I have analysed communicative practices in depth and in detail to generate theoretical understandings (Morse 1997b), in other words, to deepen understanding of doctor-patient interaction rather than to numerically represent doctors and patients.

I have sampled in different ways for different reasons in this thesis (see chapter 3).
I sampled medical texts to delineate discourses about URTI illness and consulting and also to review the knowledge that different methodological approaches can yield (see chapters 1, 2 and 4). I sampled doctors and patients, seeking a diverse sample in order to explore communicative patterns in URTI consultations (see chapters 3 and 4).
I analysed communicative practices within consultation data, selecting coughing for in-depth analysis (chapter 5) and choosing a 'telling' case study comprising one consultation with linked interviews (chapter 6). The products of my research are analyses of communicative practices (which I term 'findings' for convenience), and a critique of traditional research methods (which I term 'methodological critique').

My findings about communicative practices have the most direct relevance for URTI consultations in the UK since I have set the study in a UK ethnographic and discursive context (see chapter 4). Setting the study in Hackney yielded a socio-demographically diverse sample of doctor and patient study participants, giving me a good range of cases in which to search for discrepant examples of communicative practices (Miles &

Huberman 1994) (see chapters 3 and 4). As discussed before, I focus on communicative practices, so the sample for analysis comprises 'cough clips' and a case study rather than 'doctors' and 'patients'.

My sample was diverse but not statistically representative of Hackney residents: for example, the recruitment criteria excluded those who do not speak English fluently and there were very few recent migrants in the patient sample. There are important differences in patterns of interaction in consultations involving doctors and patients with different linguistic expectations (Roberts et al. 2004) and my findings about communicative practices may not be directly applicable to different linguistic communities, although findings are likely to be applicable on a more theoretical level. For example, coughing may not be used as a resource in consultation in particular cultural groups, but on a more abstract level my analysis shows that paralinguistic features of talk are important in shaping meaning. Similarly, coughs and colds may not be discursively constructed as 'minor' in other cultures (Hudelson et al. 1995), but on a more theoretical level, it is likely that negotiating the legitimacy of illness is important in meetings between patients and health carers in any culture. In other words, these findings are theoretically applicable to other populations and other settings.

I shall discuss the theoretical transferability of my ideas on two levels: firstly, the implications of my analysis of communicative practices (my 'findings') for doctors and patients in URTI consultations. Secondly, I shall consider the implications of my methodological critique for those producing and consuming primary care consultation research, in other words for medical teachers, practitioners and researchers.

Credibility/plausibility

I have explained the way that philosophical approaches in constructionist research differ from those of quantitative, positivist research (see chapters 1, 2 and 3). The quality of research should be judged by criteria which are consistent with its underlying paradigms: the reliability and validity criteria of quantitative positivist paradigms are not applicable in the same way to qualitative endeavour since research aims, methodology and outputs differ in nature (Chapple & Rogers 1998; Elliott et al. 1999; Malterud 2001). For example, positivist procedures for checking validity and reliability reflect efforts to fix single meanings for research findings (Mays & Pope 2000) whereas constructionist research positions itself as interpretive, with multiple meanings possible (see chapters 2 and 3). Credibility and plausibility are therefore alternative criteria upon which to judge the quality of qualitative research (Morse 1997b). Faithfulness to the

data is another criterion which may be appropriate for qualitative research, although this depends upon the aims of the research (Blaxter 2000).

My findings emerged from detailed exploration of data rather than from testing an a-priori hypothesis (Strauss & Corbin 1998): at the time I collected the data, I knew that I was interested in doctor and patient 'roles' and asked about these in interview, but did not know that coughing or social construction of illness and identity would become my main analytic interest. However, whilst my analytic topics emerged from, and are grounded in, the data, my interpretations have gone beyond what was evident in the data (see chapter 3). For example, I have described patterns in the placement of coughing (in other words I described 'what was there') but drawn upon theoretical frameworks (e.g. conversation analysis) to notice what was there in the first place, and drawn upon knowledge of normative patterns in turn-by-turn interaction and social scientific theory to interpret the meaning of what was going on.

A discursive approach analyses 'respondents' meanings' as they are evident in ongoing interaction (for example that an utterance is understood as a question, or that a position is taken as 'accountable') (see chapters 2, 5 and 6): I have not returned to respondents to check that they agree with my interpretations for two main reasons: firstly, the thesis focuses on processes in interaction and I am not claiming to represent the viewpoints of participants (for example their thoughts and feelings) (Sandelowski 2006). The communicative practices I have analysed are implicit and taken-for-granted, so it might be difficult for respondents to comment on my interpretations of them. Secondly, I present this thesis as one viewpoint and it does not present a problem to say that there are likely to be other valid interpretations of these data (see chapters 2 and 3).

There are strong ethical and theoretical arguments for 'user involvement' in research, but debate about what this actually means (Oakley 1993). 'URTI consultations' were suggested as an area of interest in a national review of priority areas for primary care research (MRC 1997) (see chapter 1) and also suggested by local practitioners in Hackney (Graffy 2000). Patient involvement in research or provision of services tends to focus on chronic disease (Baxter 2001) and URTI is not a particular priority for patients. However, my research is 'user-focused' in that I have taken the topics and activities of respondents' interaction as foci for my analysis, in other words, their priorities in interaction.

Other people have looked at my data and writing which has challenged my assumptions and interpretations and enriched analytic ideas. However, I have not used

procedures such as independent coding or triangulation in an attempt to agree single meanings for data (Harper 2003; Mays & Pope 2000) (see chapters 2 and 3). I have analysed data systematically (see chapter 3), and present worked examples so that readers can judge whether my interpretations resonate with the data: in other words to check the credibility and plausibility of analytic claims (Morse 1997a).

Implications of findings for doctors and patients in URTI consultations

Implications for doctors, patients and medical educators

There is a wealth of research focused on doctor-patient communication (Bower et al. 2001). A prominent theme in primary care consultation research is the analysis of tasks in consultation and doctors' communication skills, comparing practice with 'ideal' models of communication (Byrne & Long 1976; Kurtz et al. 1998). Taking the consultation I chose for a case study in chapter 6, an analysis of the doctor's consultation skills may have concluded that he was reasonably 'patient-centred', probably scoring quite highly in the five principal domains of a patient-centred model: 'exploring the experience and expectations of disease and illness', 'understanding the whole person', 'finding common ground regarding management (partnership)', 'health promotion', 'enhancing the doctor-patient relationship'; and 'the realistic use of time' (Brown et al. 1995); the doctor's refusal of antibiotics was consistent with evidence-based principles so could be judged to be 'good practice' (see chapter 1); a thematic qualitative analysis of post-consultation interviews with doctor 9 and patient K would have revealed no significant misunderstandings (Britten et al. 2000), no hidden agendas (Barry et al. 2000), and a doctor and a patient who said that they were satisfied with the consultation.

My analyses have not compared actual interaction with models of 'ideal' doctor-patient interaction (Maynard & Heritage 2005) but have explored patterns and processes in URTI consultations. These insights can inform understandings of why communication feels difficult or 'goes wrong' in consultation (Gumperz 2001; Roberts et al. 2005). In contrast to task-orientated analyses of the consultation (above) which would have identified no real problems in the case study consultation, my discursive analysis of interaction shows that it is not so straightforward: my analysis of the structure of talk (e.g. its turn design and rhetorical design), and social actions in interaction (e.g. construction of identity and face-work (chapters 5 and 6)) show that URTI illness presents significant interactional difficulties (e.g. difficulties establishing legitimacy, and threats to face) which are skilfully dealt with by doctor and patient. Straightforward coding of talk in consultation might have concluded that both agreed on the diagnosis and treatment advice, but a more detailed unpicking of processes in consultation shows the way that the doctor's opinion carries more weight, and that the patient

shows subtle resistance to the doctor's 'no problem' diagnosis which is not directly addressed in consultation.

Appropriateness of consulting

Throughout this thesis I contend that URTI consultations tend to be positioned negatively (as trivial and inappropriate) within medical discourse, and that consulting with URTI symptoms is morally accountable. Doctors' notions of 'appropriateness' depend upon characteristics of the illness, the patient, and the social context of a consultation as well as the nature of medical endeavour itself (for example, an illness is given less legitimacy if there is no treatment available) (Horton-Salway 2001). Appropriateness is therefore a slippery concept which is negotiated in interaction (see chapter 6).

The slipperiness of appropriateness makes it hard for patients to know how it is judged, in other words, what constitutes legitimate symptoms and legitimate circumstances for consulting a doctor. There is also debate within medicine about what constitutes appropriate work for doctors: notions of appropriateness are linked with wider conceptions of medical endeavour. For example, if medical endeavour comprises the evidence-based treatment of disease, then doctors do not have anything to offer patients with URTIs (Sackett et al. 1997; Sonnad et al. 1999). On the other hand, if medicine is more concerned with the 'whole person' in a caring rather than curing capacity, then URTI consultation is positioned as appropriate work for general practitioners (Thomas 1994) (see chapters 1 and 4). URTI consultations are caught in cross-fire about the essential nature of medical endeavour (Armstrong 1984), with doctors arbitrating with each individual patient, acting as gate-keepers to patient-hood and medical services (Erickson & Schultz 1982). This analysis shows that legitimacy is negotiated rather than self-evident, and that judgements of legitimacy are moral in nature: the case study in chapter 6 demonstrated the way that URTI illness was de-medicalised in interaction.

An understanding of this discursive context for URTI consultations may help doctors to understand the sources of negative reactions to patients and their illnesses and to place these judgments in the context of wider debate about medical endeavour. Awareness of the slipperiness of concepts of legitimacy could also help patients to understand inconsistent and contradictory receptions at the doctors' surgery. It would help patients to know that legitimacy is judged on moral and social criteria as well as 'medical' ones, and to understand the medical discourse that underpins doctors'

decisions (e.g. evidence-based practice and policy efforts to reduce 'inappropriate' consulting) (see chapters 1 and 4). Doctors' 'hidden agendas' of trying to discourage patient attendance for URTIs could be addressed directly in discussions with patients about what constitutes 'legitimate' consulting.

Patients' and doctors' dilemmas in URTI consultations

Doctors' negative constructions of URTI illness and patients with URTI and the moral accountability of consulting is of great consequence for patients. Patients encounter dilemmas about how to present themselves and their symptoms, treading fine lines between being seen as too quick to consult, or neglectful in leaving things too late (see chapters 4 and 6). Patients' accounts must convey a sense of the seriousness or importance of their symptoms in order to justify a visit to the doctor, but must also convey that they are not hypochondriacs or using services inappropriately. I have demonstrated in chapter 6 the way that the patient's account in consultation is structured to negotiate these dilemmas: patient K constructs a moral identity as a good person/patient who has tried to self-care and cope with his illness, but was driven to consult by the severity of his symptoms. Patient K did considerable work in accounting for his illness and himself, acknowledging that his illness could be interpreted as minor, but arguing that it should be seen instead as significant and 'doctorable'. Chapters 5 and 6 show that patients draw upon a range of resources to present themselves and their symptoms as legitimate. For example, verbal description, gesture and paralinguistic features of talk such as emphasis, volume and speed all contribute to constructing a persuasive account. Cough is a flexible paralinguistic resource which helps to establish patients' legitimacy: in chapter 5, I showed that coughing can help to demonstrate the physical presence and nature of illness. I discuss coughing further below.

The 'trivial', 'inappropriate' status of URTI creates problems for doctors as well as for patients: doctors' identity is bound up with being seen as skilful and professional, and URTI consultations threaten this identity (see chapters 4 and 6). For example, in 'trivial' consultations doctors cannot exercise the clinical skills which characterise their special expertise, and having no prescription to give patients removes a powerful symbol of doctor identity. Doctors face contradictions about what constitutes good doctoring in URTI consultations: for example behaving in a 'rational', evidence-based way (refusing to prescribe antibiotics or 'ineffective' remedies) conflicts with patient-centred negotiation of treatment ('concordance') (Cox et al. 2004; Gwyn & Elwyn 1999).

Doctors and patients are involved in a contest to define the meaning of URTI illness, and therefore its doctorability (see chapter 6). In the case study, patient K sought to show that his problem was a medical problem, whilst the doctor sought to show that it was not. The doctor drew on powerful professional resources to de-medicalise the patient's problem, for example vague formulations which avoided medical labelling, citing 'minimal' evidence from physical examination, and declining a prescription (see chapter 6). The 'no problem' diagnosis was carefully designed by the doctor to avoid direct threats to the patient's face, and the patient did not directly resist the diagnosis. However, a direct challenge to doctors' diagnoses or treatment advice threatens doctors' identity as expert and skilled (as represented in the email, chapter 6). Where patients expect medication, prescribing may legitimise the patient's visit and meet patients' hopes that doctors can treat or cure illness, but at the same time threaten doctors' self-conceptions as rational and evidence-based practitioners (see chapters 4 and 6). However, even if a path is found through URTI consultations which saves face for both patient and doctor, a 'no problem' diagnosis risks being seen as a waste of time for both (see chapter 6).

The contest over the meaning of URTI symptoms is weighted in doctors' favour, since they have access to institutionally authoritative rhetorical resources such as citing evidence from physical examination and the naming of illness. Patients do not usually directly challenge doctors' diagnoses (Perakyla 2006). However, paralinguistic resources such as hesitation and coughing can serve to subtly challenge doctors' formulations and keep discussions open (although not leading to revision of decisions in this data set). It would help patients to understand the institutional order of consultations, for example, the purpose and nature of activities and tasks in consultation including the norms for presenting oneself and one's symptoms (Roberts et al. 2004). 'Communication skills' for patients could include learning how to present oneself as a legitimate patient, and learning how to contest doctors' decisions without threatening doctors' face for example.

Consulting with URTI is morally accountable and patients' face is vulnerable in URTI consultations. As shown in chapter 6, it takes skill to refuse requests in a face-saving way, and this skill could be included in communication skills teaching for doctors. If doctors wish to discourage consulting, they could redefine situations to save patients' face by redefining situations positively, emphasising self-care abilities for example, rather than addressing the illegitimacy of consulting. Redefining illness metaphors is also a useful way of suggesting new meanings and ways of collaborating (see chapters 2 and 6).

I suggest that awareness of the discursive context for URTI consultations, and the importance of legitimate identities and maintenance of positive face for both doctors and patients could make communication in 'minor' consultations more satisfactory for both doctor and patient.

I have discussed the implications of my findings for medical practice, and will now discuss the implications of my critique of methodological approaches.

Implications for consultation research

I have discussed the methodological implications of discursive approaches throughout this thesis, but in this section I shall discuss the challenge to traditional primary care research presented by discursive approaches.

Qualitative consultation research

I have argued that qualitative approaches offer significant advantages for consultation research, allowing exploration of the complexity of social phenomena from respondents' points of view, and keeping a sense of the social context of events including the research process itself (see chapter 2). Qualitative studies often combine analysis of recordings of consultations with post-consultation interviews as I have done (e.g. Britten et al. 2000). However, discursive approaches point to the problems in taking interview content literally, pointing out that utterances have meanings best understood by reference to the social actions of talk (for example, 'thinking positive', chapter 2). Discursive approaches therefore contend that interviews do not allow straightforward access to 'what really happened' or 'what participants really think' (see chapter 3). I have argued that interviews can be an ethnographic resource to understand the wider contexts of social phenomena, and can also offer insights into how respondents talk about events and use particular terms and concepts (see chapters 3 and 4). I have drawn upon doctor and patient interview data in this way, placing my micro-analyses of social interaction within a discursive and ethnographic context, drawing on documents as well as interview data. However, to understand interactions between doctors and patients, there is a strong case for directly studying 'naturally occurring' interactions rather than conducting post-hoc interviews, as I discuss below.

Discursive views of interaction in consultation

Discursive, constructionist approaches conceptualise 'doctor-patient communication' quite differently from traditional research approaches, seeing talk as orderly and complex, and meaning as actively co-constructed in interaction. As I show in chapter 5, the fine details of interaction have communicative significance, for example the exact placement of overlapping talk, pauses or coughing. Detailed analysis reveals the complex co-ordination of verbal utterances with paralinguistic features of talk and body conduct, for example cough and averted gaze in association with 'recipiency' or cough with hand gestures to demonstrate symptoms (chapter 5). Chapters 5 and 6 also reveal the co-construction of meaning in doctor-patient talk. For example, coughs do not have a universal meaning, but individual meanings depend upon the interactional context: a cough in a turn where agreement is expected but missing 'means' something different to a cough which occurs in the context of giving accounts of symptoms. In the case study in chapter 6, the doctor's and patient's constructions of URTI illness are different and competing (significant and severe vs. 'no problem'): a joint meaning is negotiated in consultation.

Discursive analyses allow insight into the social actions of talk (see chapter 2). For example, on a micro level, ongoing assumptions and expectations maintain talk as orderly and intelligible: in example 6 in chapter 5, failing to answer a question is accountable, and the doctor re-phrases the question to pursue an answer. In other examples, coughing alters the direction of doctors' questioning, prompting new questions about symptoms, or helping to re-open topics for further discussion (see chapter 5). The main focus for my analysis of social action is the construction of identity as a doctor or patient. I have argued that this is partly constructed by the institutional setting and mutual expectations of roles, and partly constructed in ongoing talk (see chapters 2, 5 and 6). An appreciation of the complexity of social interaction helps to explain what is happening in consultation. For example, much that is said may appear irrelevant to medical tasks in consultation. However, apparently irrelevant detail in accounts helps to construct doctor and patient identities, and to maintain positive face (see chapter 6).

A discursive conception of interaction leads to a re-conceptualisation of the nature of talk between doctor and patient in consultation. To take the example of symptom talk, a biomedical, positivist view sees talk as a means through which doctors establish the facts about patients' illness (Silverman J et al. 2005): doctors' questions function to 'take a history', in other words establish particular information about the nature and course of illness in order to interpret the patient's symptoms in terms of specific

disease categories (Kumar & Clark 2005). The metaphor 'take a history' sums up a biomedical view of symptom talk, in portraying the facts as residing in the past and in the patient, awaiting extraction by the doctor. In contrast, a discursive model of meaning-making means that 'taking a history' is not simply recall of static past events, but brings new meanings to an experience through its retelling (Silverman D, 1987). I have shown in my analysis that URTI illness is constructed in consultation rather than simply described, and that the meaning of URTI is contested and negotiated (see chapter 6), so a more suitable metaphor would be to 'make a history'. The medical metaphor for diagnoses is to 'make a diagnosis' and this is in fact quite a suitable term.

Discourse approaches can explore the match between ideals for 'good' communicative practice and events in actual interaction (Maynard & Heritage 2005; Roberts et al. 2003). For example, my analysis questions whether concepts of 'patient-centeredness' are sufficiently complex and grounded in analysis of actual interaction. As the case study shows, interactional asymmetry is collaboratively produced by both doctors and patients, but the patient's verbal agreement in consultation does not necessarily mean that this was a 'patient-centred' interaction: the 'agreement' was heavily weighted in favour of the doctor's view. Analysing talk alone (for example verbal agreement) may miss the subtle resistance signalled in paralinguistic features of talk such as hesitation or coughing. Discursive approaches offer understandings of the sophisticated interaction of body conduct and paralinguistic features of talk in communicating meaning. Video feedback is already extensively used as a resource to train doctors (Campion et al. 2002) and can usefully be used to question taken-for-granted assumptions about what constitutes 'good' communication (Roberts et al. 2005).

Implications for consultation research

What does this re-conceptualisation mean for consultation research?

I have argued that talk needs to be understood in the context of the social interaction between participants, both in consultations and in research interviews (see chapters 2 and 3). This means that recordings of naturally occurring interactions between doctor and patient (rather than research interviews alone) are preferred for discursive consultation research since these preserve the complexity and context of talk in interaction.

Discursive approaches are attentive to the context of social interaction. I have shown that 'context' is relevant on several levels: the immediate context of previous utterances and the turn-by-turn structure of talk, the context of the social interaction between participants, and also the wider context of discursive ideas. The ethnographic and discursive context that I have drawn upon (see chapter 4) is wider than the immediate interactive context usually taken as relevant for conversation analyses (Schegloff 1997): for example, I have considered the relevance of the institutional setting and inequality in power as well as that of wider discursive ideas (e.g. the negative positioning of URTI consultation in medical discourse). There is increasing acknowledgement that the fine details of social interaction can be usefully understood in broader contexts, for example integrating fine interactional analysis with ethnographic approaches in 'socio-linguistic ethnography' (Sarangi & Roberts 1999; Heritage & Maynard 2006).

Discursive approaches are also attentive to the complexity of social interaction (see chapters 5 and 6). Detailed transcribing of recordings of naturally occurring interactions (including paralinguistic features and body conduct) captures this complexity, and facilitates 'analytic noticing' which is not possible with researcher-orientated research designs (see chapters 2 and 3). Discursive approaches can take participants' topics and activities as foci for analysis, in other words their priorities in interaction, and can therefore be more respondent-centred (see chapter 3).

Finally, discursive approaches are attentive to social actions accomplished by talk (see chapters 2, 5 and 6). Analysis of the structure of accounts and the functions of talk can reveal dimensions of social interaction which would not be evident on analysing the content of talk alone, and can give a fuller picture of what is happening in doctor-patient interaction.

Discursive approaches offer methodological challenges to traditional consultation research, suggesting that simplistic, de-contextualised research on communication in consultation should not be accepted as adequate evidence to underpin recommendations for good practice. Discursive analyses have powerful explanatory power which can enrich understandings of doctor-patient interaction, providing 'evidence' which is respondent-centred and grounded in analysis of actual interaction. Discursive approaches are well established in social scientific disciplines such as socio-linguistics, discursive psychology and sociology: primary care research is enriched by collaboration with social scientists, but has yet to fully embrace discursive approaches.

Discursive approaches offer not only exciting ways of researching doctor-patient consultations, but also offer fundamental challenges to scientific paradigms of medical endeavour (Elwyn & Gwyn 1999; Gwyn 2003; Mathers and Rowland 1997).

Science

You sit on the outside
Using high technology
Looking inside me
At my curious biology

Sophisticated games
With my blood and bones
An interesting spectacle
In a world of your own

Flesh becomes flesh
Thoughts are incidental
Body is body
The rest is sentimental

I'm one of many
You'll keep in perspective
But for the moment
I'm the one you've selected

I'm matter in your hands
The object of your action
Peer down a microscope
At a chemical reaction

You have no time
For my suspicious evasion
A formula should be enough
A perfectible equation

If I dare to question
Your well-prepared position
You'll dismiss my words
As so much superstition

The gaps in the answers
The untied threads
The unanswered questions
Go round in your head

And today things are different
What has changed for you?
You're waiting for my answer
You've missed your cue

You seem to want to hear me
You're looking less assured
What is the question
If the answer isn't 'cured'?

When I look at you
And glimpse your soul
We both know there's more
Than a material goal

Look at me and give me
Direct communication
And use your science
For amazing transformation

Fiona Hamilton

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Appendix 1 – Doctor invitation letter

(Date)

Dear Doctor

Consultations for upper respiratory tract infections

Invitation to participate in a research project

Consultations for upper respiratory tract infections (URTIs) can be associated with misunderstanding and dissatisfaction for both patients and doctors.

This research project aims to explore reasons for any misunderstandings or difficulty communicating in consultations for common respiratory symptoms, and generate ideas about how misunderstandings or conflicting expectations could be reconciled.

The project involves videotaping consultations with 1-2 patients who are attending with self-limiting respiratory symptoms, and an interview about the consultation afterwards using play-back of the sound track. Patients would also be interviewed with their permission.

The project has ethical permission from the East London and the City Ethical Committee.

The interview will focus on issues for doctors and patients when the presenting complaint is 'minor' or self-limiting. Review of consultations using play-back of the sound track could constitute a learning activity for the 'Maintaining Good Practice' part of the GP appraisal process.

Thank you very much for your interest

Dr Julia Bailey

020 7848 4143/ 07766 617 783, or julia.bailey@kcl.ac.uk
King's College Department of General Practice and Primary Care, 5 Lambeth Walk, London SE11 6SP.

Appendix two – Doctor consent form

INVITATION TO PARTICIPATE - DOCTORS

Communication in Consultations for Upper Respiratory Tract Infections

King's College London

Invitation to Participate in a Research Project

I invite you to take part in a research study which I think may be important.
The following information tells you about it. It is important that you understand what is in this leaflet. It tells you what will happen if you take part. It is up to you to decide whether or not to take part in this research. Please ask any questions you want to about the research and I will try my best to answer them.

- You are invited to participate in this study because you are a GP working in Hackney

- The aim of this research is to understand more about communication between doctors and patients in consultations for upper respiratory tract infections (URTIs), particularly the sources of any misunderstanding or difficulty in communication.

- If you agree to participate in the study, this would involve the video recording of 1-2 routine consultations with patients who are consulting with URTI symptoms.

- I would also like to interview you about your experiences of patients consulting with URTI symptoms, and your view of video-taped consultations, using play-back of the video to prompt discussion. An initial interview would take about an hour, and any subsequent interviews would take approximately 10-15 minutes per patient.

- You might find it uncomfortable being video-taped or interviewed. If this happened, you would be free to stop the recording or interview at any time.

- All of the information obtained will be treated as strictly confidential, and no participants will be identifiable once the data has been transcribed (all participants will be given a study number). Videos of consultations and interview data will be kept in a locked cabinet and seen only by the research team. Results from the project will be written up anonymously.

- If you agree to take part in this study, you would be completely free to withdraw at any point

If you have any questions or worries about the research, please contact

Name: **Dr Julia Bailey**

Address: **Department of General Practice and Primary Care, 5 Lambeth Walk, London SE11**

Telephone number: **020 7848 4143/ 07766 617 783**

E-mail **Julia.bailey@kcl.ac.uk**

DOCTOR WRITTEN CONSENT FORM

Communication in Consultations for Upper Respiratory Tract Infections

REC Number:

Name of Doctor (Block Capitals):

Address:

- The study organisers have invited me to take part in this research. ☐
- I have understood the information leaflet about the research. I have a copy to keep ☐
- I have had the chance to talk and ask questions about the study. ☐
- I know what my part will be in the study and I know how long it will take. ☐
- I know how the study may affect me. I have been told if there are possible risks. ☐
- I know that the East London and The City Research Ethics Committee has seen and agreed to this study. ☐
- I understand that personal information is strictly confidential: I know the only people who may see information about my part in the study are the research team or an official representative of the organisation which funded the research. ☐
- I understand that my personal information may be stored on a computer. If this is done then it will not affect the confidentiality of this information. All such storage of information complies with the 1998 Data Protection Act. ☐
- I freely consent to be a subject in the study. ☐
- I know that I can stop taking part in the study at any time. ☐
- I know that if there are any problems, I can contact:

Dr Julia Bailey, 5 Lambeth Walk, London SE11 6SP
Tel. No. 020 7848 4143

Doctors' Signature .....

Date .....

The following should be signed by the Investigator responsible for obtaining consent

As the Investigator responsible for this research or a designated deputy, I confirm that I have explained to the doctor named above the nature and purpose of the research to be undertaken.

Investigator's Name: .....

Investigator's Signature: ..... Date: .....

Appendix 3 – patient recruitment card

RESEARCH PROJECT

ARE YOU GOING TO SEE THE DOCTOR WITH ANY OF THESE SYMPTOMS ?

SORE THROAT

RUNNING NOSE

COUGH

COLD

FLU ?

ARE YOU OVER 16 ?

A RESEARCHER IN THE SURGERY TODAY WOULD LIKE TO TELL YOU ABOUT A RESEARCH PROJECT

For further details contact Dr Julia Bailey: Telephone 020 7848 4143
Department of General Practice and Primary Care, 5 Lambeth Walk, London.

Appendix 4 – patient consent form

INVITATION TO PARTICIPATE – PATIENTS (consultation and interview)

Communication in Consultations for Upper Respiratory Tract Infections

King's College London

Invitation to Participate in a Research Project

I invite you to take part in a research study. The following information tells you about it. It is important that you understand this information which tells you what will happen if you take part. It is up to you to decide whether or not you do take part. Please ask any questions you want to about the research and I will try my best to answer them.

- You are being invited to participate in this study because you are visiting the doctor today with a cold, cough, running nose, sore throat or flu

- The aim of this research is to understand more about how doctors communicate with patients who have symptoms of cold, cough, running nose sore throat or flu

- If you agree to participate in the study, I would ask you to agree to a video recorder being on while you see the doctor today.

- In addition to the video recording, I would like to interview you at home afterwards to ask you questions about your illness, and your experience with the doctor. Interviews would take around one hour.

- I hope that this research project will interest you, and you find it useful to discuss your health, and your visit to the doctor. I hope that lessons from this project will help doctors and patients to communicate better

- If you find it distressing to be video taped or interviewed, you would be free to stop the video tape or the interview at any time. I would refer you to a counsellor or support service if this was needed

- All of the information obtained will be treated as strictly confidential. Participants will be given a study number so that no individual will be identifiable. Videos of consultations and interview data will be kept in a locked cabinet and seen only by the research team. Results from the project will be written up anonymously.

- If you agree to take part in this study, you would be completely free to withdraw at any point.

- If you decide not to be in the study, or drop out, this will not put at risk your ordinary medical care.

If you have any questions or worries about the research, please contact

Name: **Dr Julia Bailey**
Address: **Department of General Practice and Primary Care,**
5 Lambeth Walk, London SE11

Telephone number: **020 7848 4143/ 07766 617 783**

E-mail julia.bailey@kcl.ac.uk

CONSENT FORM

Name (Block Capitals): **Telephone no:**

Address: **E-mail address:**

- The study organisers have invited me to take part in this research. ☐
- I understand the information about the research. I have a copy of this information to keep. ☐
- I have had the chance to talk and ask questions about the study. ☐
- I agree to the video-taping of my visit to the doctor ☐
- I agree to being interviewed after my visit to the doctor. ☐
- I know what the study involves. I have been told if there are possible risks. ☐
- I know that the East London and The City Research Ethics Committee has seen and agreed to this study ☐
- I understand that personal information is strictly confidential: I know the only people who may see information about my part in the study are the research team or an official representative of the organisation which funded the research. ☐
- I freely consent to be a subject in the study. ☐
- I know that I can stop taking part in the study at any time. ☐
- I know the researchers may tell my GP if they have particular concerns about my health which arise during the course of interviews. ☐
- I know if I do not take part I will still be able to have my normal treatment. ☐
- I know that if there are any problems, I can contact:

Julia Bailey, 5 Lambeth Walk, London SE11 6SP
Tel. No. 020 7848 4143 /07766 617 783

Patient's: Signature .....

Date .....

The following should be signed by the Investigator responsible for obtaining consent

As the Investigator responsible for this research or a designated deputy, I confirm that I have explained to the patient named above the nature and purpose of the research to be undertaken.

Investigator's Name: .....

Investigator's Signature: ..... Date: .....

PART TWO

Following the consultation

I am **still willing** for my consultation to be used in the research/
I am **not** willing for my consultation to be used in the research (please delete one)

Patient's Signature .....

Date .....

Thank you for your help with this project. To help us to understand more about communication between doctors and patients, I would like to interview you later about your visit to the doctor

Please tick one of the following options:

☐ I agree to be interviewed, at home

☐ I agree to be interviewed, at King's College, 5 Lambeth Walk

☐ I agree to be interviewed, at the doctors' surgery

☐ I do not wish to be interviewed

Name .....

Appendix 5 –Topic Guide for Doctors

Doctor-patient communication in consultations for upper respiratory tract infections

Introduction:
Me: (trained as a GP, now doing research), from Kings College, not PCT

Aim:
To find out about your experience of consulting with those who come with upper respiratory infections. I used to find it hard to know the best way of managing URTI consultations.

Consent:
Consent for interview, check acceptability of showing of video clips and audio-recording interview

Confidentiality:
Videos and tapes kept locked. Seen by me and supervisors only. Codes on interview transcripts, anonymous quotations. Comments won't be fed back to patients interviewed

Will ask questions about patients in general, and then about the patient we video-taped.

Semi-structured interview; i.e. I have a list of areas to cover, but structure is flexible

Less interested in the evidence, adherence to guidelines for example, but instead what works in practice.

Questions may seem silly, or answers obvious; I don't want to assume things which are not right.

No right or wrong answers, not assessing performance. Contradictions are interesting

Anything you would like to ask about me, or the project?

Experience

N.B. Adults with URTIs

Are consultations for URTIs common?

What comes to mind in thinking about patients with URTIs?

Do you usually find URTI consultations straightforward?

Are they a prelude to other problems?

Video taped consultation

Going to play the tape of a consultation in order to jog memory about this particular patient

Interested in what your aims were in consultation
Any difficulties in communication
Any dilemmas for you
How you felt

Avoid comparisons with an MRCGP 'ideal' consultation
Were there difficulties in communication?

Were there dilemmas in this consultation (about the diagnosis, or treatment, or other factors) ?

Context of appointment:

Which surgery session was it, and how was it going?

How well do you know this person?

What were your first thoughts?

Nature of complaint:

What did you feel was wrong? How serious was it?

What do you see as the cause of the patients complaint(s)?

What would happen if untreated?

Consultation process:

What were your aims (e.g. advice, examination, prescription)?

What was the outcome?

Was the outcome satisfactory for you? How about for the patient?

How appropriate do you feel this consultation was?

Do you feel that your view of your role fits with what the patient was expecting from you?

How did you feel about this consultation?

How did you feel about this patient?

Consulting

Were these typical consultations?

Do you try to get across particular messages about (viral/self-limiting) illness?

Do you try to get across particular messages about treatments?

Do you try to get across particular messages about re-consultation?

How do you feel about your job at the moment? (prompt workload, satisfaction, nature of daily tasks)

Is treatment of URTIs part of a doctor's job?

How do consultations for URTIs make you feel? (appropriate use of services) ?

Demographics (to describe the sample)

Age, gender

Cultural identity (first language, past and current residence)

Length of time as a GP, part-time/full time

Any other comments?

Appendix 6- Topic Guide for Patients

Doctor-Patient communication in consultations for upper respiratory tract infections

Introduction:
Me (trained as a GP, now doing research) from King's College, not the practice or government

Aim:
Purpose is to find out about your experience of being unwell, and of going to the doctor Advice given by doctors sometimes doesn't make sense to patients.

Consent:
Written consent for interview and audio-taping. Check acceptability of looking at clips from video-taped consultation.

Confidentiality:
Tape recordings and any writing will be kept securely. Seen by supervisors and me only. Would like to use anonymous quotations. Your opinions won't get back to doctors

Questions may sometimes seem silly, or answers obvious, but I don't want to assume things which are not right. Whatever your opinions are they will be really useful.

Anything you would like to know about me or the project?

Your health

How are you at the moment?

Can you tell me about when you were ill?

Prompt:
What are/were the cause(s)?

Are you particularly susceptible?

How serious do you feel it was?

Have you used any treatments? (self-help, OTC, prescribed) (check whether before or after Dr visit)

What would have happened if it was not treated?

Did you talk to anyone else about being unwell? what did they say ?

Visiting the doctor:

What were you hoping for from your visit to the Dr?

Was it a difficult to decide whether to go?

Which problem was the main reason for visiting the Dr?

Video-taped consultation

Going to play the tape of a consultation in order to jog memory about the visit

Going to play it in sections, and then ask about your thoughts and feelings

Purpose is in order to make sure I understand the meaning of what was happening

Context of appointment:

How well do you know doctor X?

How was your day going up to the appointment you had?

What sort of appointment was it?

Hidden agenda:

Was there anything on your mind that you didn't mention?

Diagnosis:

Did the doctor say what was wrong?

How did the doctor know this?

Do you agree?

Advice:

What do you think about advice the doctor suggested?

Treatment:

What do you think about treatment the doctor suggested?

Were there any difficult parts of the consultation?

Were there any disagreements do you think?

Overall how do you feel about this visit?

How did you feel about your illness by the end? (wellbeing, worry, satisfaction, feeling silly ?)

Was your experience this time typical of other visits?

About yourself

Age, gender

Who usually helps you if you are ill?

Are you in work?

What is your cultural identity? (first language, past and current residence, cultural identity)

Any other comments you would like to make?

Appendix 7- Transcription Conventions

( ) talk too obscure to transcribe.

Hhhhh audible out-breath

.hhh in-breath

[overlapping talk begins

] overlapping talk ends

◦ lower in volume than surrounding talk◦

>noticeably faster than surrounding talk<

(.) silence, less than half a second

(..) silence, less than one second

(2.8) silence measured in 10^{ths} of a second

:::: lengthening of a sound

Becau- cut off, interruption of a sound

He says. Emphasis

= no silence at all between sounds

LOUD sounds

? rising intonation

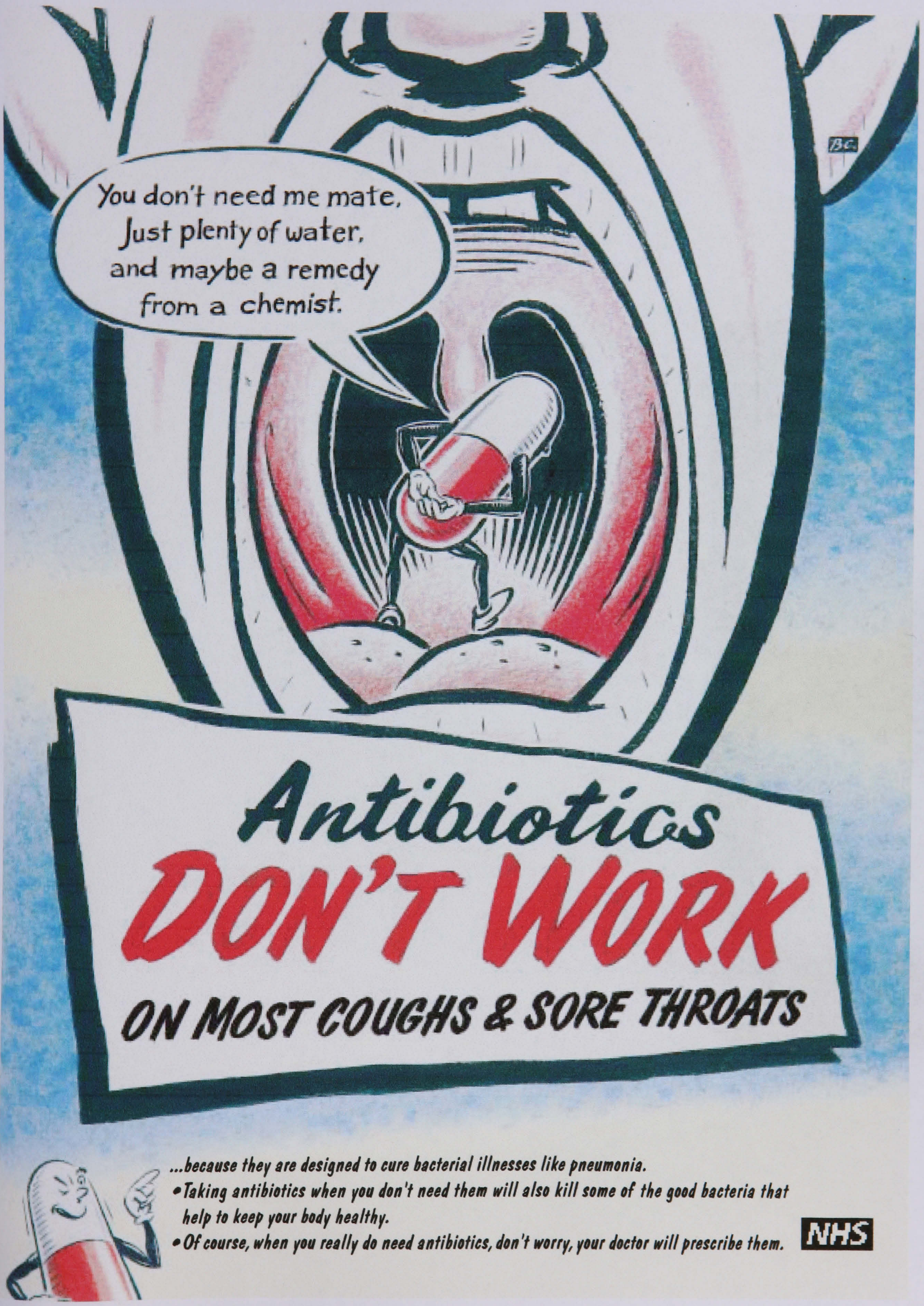
[my comments]

[…] lines of talk omitted

(blue font colour) body conduct, non-lexical verbalisations

k; KK; KK	*increasing volume of cough*
km	*throat clearing sound*
KKhh	*wheezy cough*

Appendix 8- Photograph of video camera



...because they are designed to cure bacterial illnesses like pneumonia.

- *Taking antibiotics when you don't need them will also kill some of the good bacteria that help to keep your body healthy.*
- *Of course, when you really do need antibiotics, don't worry, your doctor will prescribe them.*

NHS